The Discursive Construction of Complementary and Alternative Medicine (CAM) in Women's Popular Health Media and Medical Journals

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Dedication

This thesis is dedicated to my grandmother, Catalina Fernandez for her inspiration in understanding other ways of knowing, and to my daughter, Naomi.

Abstract

In this dissertation, I examine how CAM is discursively constructed in four major biomedical journals, *The Journal of the American Medical Association, Nature, Science,* and *The New England Journal of Medicine*, and three widely known women's popular health media sites, *The Dr. Oz Show, Women's Health* magazine, and *Prevention* magazine, and argue that risk is a major trope in the construction of CAM. In my analysis, I found that medical journals use risk discursively to circumscribe the extent to which CAM is accepted in the mainstream medical community and to reinforce institutional boundaries. In women's popular health media, I found that risk is used discursively to reinforce the importance of conventional beauty standards while also supporting CAM as a valid supplement to conventional medicine by emphasizing how using CAM may enhance or improve health. Finally, I argue that although medical journals use the risk of CAM to validate professional norms, and women's health media conflate health and appearance using CAM, women's popular health media also provide specific examples of resistance against both the construction of the riskiness of CAM by medical journals and the patriarchal discourses that inflect the popular media's coverage of CAM.

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Chapter One: The Discursive Construction of Risk in Women's Health

The July/August 2013 issue of *The Atlantic* featured a story about the media panic in the early 2000s around the drastic decline in women's fertility after age 35[i]. The author of the article, Jean Twenge, a psychologist who was childless and single at 30, described the anxiety she felt when reading this coverage which featured alarmist headlines such as "Baby Panic," (*New York Magazine*) or "Should you have your Baby now?" (*Newsweek*). When she decided to go to the medical journals herself to mine the data that was presented in these magazines she found that the majority of information presented there was based on a study which used rates on women's fertility from birth records dating from 1670-1830. When she researched more contemporary studies she found that women's fertility did not significantly decline until after age 40. The media panic over women's fertility was by no means innocuous to women's lives, as Twenge points out. In her description of her own experience and of women's online discussions about childbearing after age 35, she observed that many women discussed either scaling back careers to have children earlier, or had fewer children than they wanted to because of the seemingly daunting task of conceiving in their late 30s. Twenge's story illustrates some of the main points that I make in my dissertation: scientific studies are selectively chosen by the media, and many of these present stories about health risks that are often not based on the best available scientific research. In addition, these manufactured risks can and do function in the oppression of women.

The second story I use as a springboard to my topic connects to my specific area of study—Complementary and Alternative Medicine (CAM)—and is a bit more abstract.

My Cuban-born grandmother is a devout Catholic and often used to pray to San Dimas (Saint Dismas) to help her find lost things. Dimas is a saint not officially canonized by the Catholic Church or named in the Bible[ii], but one who was recognized among some in Cuba. The prayer also involved a ritual: she would tie a string around a piece of furniture, pray to Dimas and promise to do some good deed (such as give money to the poor) when the item was found. Although there was no "proof" that Dimas was intervening, Abuela always seemed to find what she was looking for, at which point she would fulfill her promise and cut the string tied to the furniture. I use this example to illustrate how people negotiate uncertainty in their lives and how they may use rituals, prayer, or other methods that do not fall within a rationalist objective framework in order to make sense of their lives. I argue this may be even more widespread when it comes to health, as people are often willing to try various methods, CAM included, in order to be healthy.

In this dissertation, I examine how CAM is discursively constructed in medical journals and women's popular health media and argue that risk is a major trope in this construction; moreover, at times, risk functions to oppress women by conflating health with appearance or emphasizing the individual mediation of risks to the exclusion of social causes of illness. In my analysis, I found that medical journals use risk discursively to circumscribe the extent to which CAM is accepted in the mainstream medical community and to reinforce institutional boundaries. In women's popular health media, I found that risk is used discursively to reinforce patriarchal assumptions about conventional beauty and slimness being important for women to attain, while at the same time they support CAM as a valid supplement to conventional medicine by emphasizing

how using CAM may enhance or improve health. Finally, I argue that although medical journals use the risk of CAM to validate professional norms, and women's media conflate health and appearance using CAM, women's popular health media also provide specific examples of resistance against both the construction of the riskiness of CAM by the medical journals and the patriarchal discourses that inflect the popular media's coverage of CAM, therefore risk functions in ways that are both repressive and productive.

This project contributes to critical/cultural health communication studies because while critical/cultural health communication scholars have examined how power and ideology function in health messages, the ways in which power and ideology function in the discursive construction of CAM in medical journals and women's popular health media has not been analyzed. CAM is an important site to examine at this historical moment given its exploding popularity. In addition, it is important to analyze both women's popular health media and medical journals together to interrogate how they work in conjunction, as well as in opposition, to one another in their construction of CAM and health. These discourses, when analyzed together, provide insight into how CAM is being discussed in relation to women's health at this historical moment. Finally, there has been no extensive analysis of CAM within feminist media studies. CAM is important for feminist scholars to study given the historical association between the first and second wave feminist movements and CAM, and analyzing how it is constructed in the popular media provides valuable insight into how it is being constructed for mass audiences of women.

Popular media are important sites of analysis as the media are central to meaning-making—including meaning making about health—in contemporary society. As feminist media scholar Mary Douglas Vavrus (2002) notes: "The media construct particular views of the world, and through continuous interactions with these views, we mold and shape our own perspectives and orientations toward reality" (p. 3). In addition to analyzing popular media it is also important to look at medical professionals' discursive constructions of CAM because analyzing them provides a full context for understanding the influence of CAM on contemporary allopathic medicine, and thus provides a robust picture of how medical professionals understand CAM. It is particularly important to study CAM from a *feminist* perspective because it has been historically associated with women—in the United States dating to at least the colonial era (Ehrenreich & English, 2005). CAM is also used more frequently by women (NCCAM, 2011), and has a long historical association with the women's health movement. For example, in the United States, the Popular Health Movement, which began in the 1830s, closely coincided with the emerging feminist movement of the time[iii] (Ehrenreich & English, 2010); the women's health movement of the 1960s and 1970s also aligned with the objectives of the second wave feminist movement (Bix, 2004). Because CAM has traditionally been associated with feminism and women's movements, analyzing how it is constructed by women's popular health media will help uncover how CAM is constructed for women today. This is important given that narratives about women's health help to construct the available range of meanings offered to women in negotiating their own health (Dubrwiny, 2013). I argue that CAM, though traditionally aligned with feminist

movements in the United States, is constructed in women's popular health media in problematic ways (for example, articulating appearance with health), and may thus be used to oppress women. By uncovering some of the patriarchal ideologies informing these discursive constructions, new ways of constructing discourse about CAM may be formulated. However, women's popular health media also at times provide feminist critiques of gender discrimination in healthcare, thus women's popular health media also provide a forum for challenging some of the oppressive tendencies they reproduce. Therefore, my project provides a feminist study of CAM that is important to the politics of women's health. Before I proceed further, I first briefly identify what I define as CAM in this project.

Complementary and Alternative Medicine (CAM)

Today, CAM is gaining widespread popularity, and women are its main consumers. Since the early 1990s, CAM has secured federal funding, been covered by some insurers, and been increasingly integrated in hospital regimens. However, CAM is a broad term used to encompass many different treatments and therapies. The National Center for Complementary and Alternative Medicine (NCCAM) defines CAM by separating it into two categories: natural products (herbs, vitamins, minerals, and probiotics) and "mind and body practices" (acupuncture, meditation, massage, movement therapy[iv], relaxation techniques[v], spinal manipulation, Tai Chi, qi gong, yoga, healing touch and hypnotherapy). They also mention some CAM therapies that fall outside of these two

categories, including traditional healers, Ayurvedic medicine, traditional Chinese medicine, homeopathy and naturopathy (NCCAM, 2013).

The broad scope of the NCCAM's definition of CAM illustrates the multiplicity of CAM practices used by the U.S. public. The public's increasing interest in the topic is also reflected in how quickly the CAM industry is growing. The NCCAM itself was created in 1998, and an increasing number of hospitals provide CAM therapies such as massage, acupuncture, and Reiki. Recent news coverage highlights this trend: one *USA Today* article published in 2008 reported that 37% of hospitals in the country provided CAM services. In 2012, only four years later, that number had risen to 42%, according to a national survey published in *The Los Angeles Times* (Andrews 2012, Paragraph 2). Although CAM therapies still are not usually covered by insurers (due to their lack of scientific efficacy), the NCCAM notes that insurers are beginning to cover some therapies such as chiropractic services, acupuncture and massage (NCCAM, 2011, Paragraph 5). Another study found that those three services were usually the only CAM therapies covered by insurance. However, CAM has become a money-making business: the NCCAM reports that consumers often pay for CAM out of pocket (Cleary-Guida, et. al., 2001), creating a nearly $20 billion dollar a year consumer industry.

Clearly the use of CAM is becoming mainstream and it is thus pertinent to explore why it is becoming popular now. Although people in the United States have a long history of CAM use, I argue that part of the public interest in CAM has to do with the ubiquity of risk discourses embedded in the media's coverage of health stories,

including those on medical errors, risks of screening technologies, and distrust of doctors and pharmaceutical companies. Before I elaborate on CAM further, I briefly explicate the main theoretical terms I use in this project: risk, risk society, choice, individualization, and reflexivity.

Risk and Risk Society

As a result of the various developments that have shaped late modernity[vi], including an increasingly global capitalist economy which is accelerated by the speed with which information travels (Boden, 2000) and a detraditionalization of the social world, in which social class and familial obligation no longer meaningfully determine an individual's life path[vii] (Lash, 2000), the Western world has been labeled by Ulrich Beck (1992) a "risk society." The thesis of the risk society is that risk has become a central component of intellectual, structural, and political rationalities, and that these rationalities are connected by multiple threads of discourse that express the crises of modernity (for example the loss of conventional mores associated with the traditional life plan, such as marriage and stable employment) and industrial society (environmental pollution related to industry) (Lash & Wynne, 1992, p. 3). Modernity is a loaded term with several possible meanings, in this dissertation (unless otherwise specified) when I refer to modernity I am using Beck's understanding of the word, which refers to a time period beginning around 1900 and continuing into the present marked by the scientific (such as biomedicine) and technological (such as the invention of the Internet) developments that have accelerated

contemporary life both in the creation of new knowledge and the ability for media to circulate this new knowledge instantaneously.

Other scholars such as Rose (2001), take an even broader perspective on the influence of risk on health discourse, arguing that it has been central to biopolitical rationalities for at least the past 150 years. Rose draws on Foucault's (1976) concept of biopolitics which provides a framework for understanding how medical discourses have been used as tools of governance to maximize life. By this, Foucault means that the modern state has had an interest in maintaining and expanding the health and hygiene of a nation, but he asserts this has not been imposed on the citizenry; rather, the discourse of health and hygiene necessitates persuading subjects to actively, willingly participate in these regimes. In this way, biopolitics is constituted by both individual activities and self-surveillance, as well as by public health initiatives, often driven by quantified information about the health of the population. Rose, too, sees risk as an informing principle in health discourse, and uses Foucault's concept of self-governance to explicate how individuals internalize risk rationalities and then take up practices (one of his examples is genetic counseling) that they believe mediate risks to themselves or close others. Although Rose's work contributes to my understanding of how health risks function in discourse, the risk society thesis has been most extensively elaborated by Beck (1992, 1999) and Anthony Giddens (1999). I reference Beck most frequently in this dissertation because I analyze media and he grants the mass media a prominent role in the construction and dissemination of risks of all kinds: personal, professional, medical, and so forth (Cottle, 2008).

Beck defines risk as characterized by, “a peculiar, intermediate state between security and destruction, where the *perception* of threatening risks determines thought and action” (1999, p. 213). These risks emerge from a society that relies heavily on expert knowledge to construct reality, and in which information about risks is in a sense “manufactured” (Giddens, 1990, 1995, and Beck, 1999) by scientists and experts. In Foucauldian terms, as a discourse, risk shapes medical knowledge and in turn helps to form particular subjectivities informed by risk. These insights are important to understanding the constructed nature of risk. For example, Beck argues that those who claim to have expert knowledge about varying risks such as scientists, business people, and politicians, are able to construct some risks as more meaningful than others as well as set the agenda for how to control and measure risks, thus creating a market for risk mediation. In addition, their claim to special knowledge about risks perpetuates social inequalities:

> As the risk society develops, so does the antagonism between those *afflicted* by risks and those who *profit* from them. The social and economic importance of *knowledge* grows similarly, and with it the power over the media to structure knowledge (science and research) and disseminate it (mass media). The risk society is in this sense also the *science, media and information* society. Thus new antagonisms open up between those who *produce* risk definitions and those who *consume* them (Beck, 1992, p. 46).

Because the risks of modern life are shaped by particular experts, risks are not ideologically neutral, but work to benefit varying stakeholders (Douglas & Wildavsky, 1982, Nelkin, 1989, and Lupton, 1993). For example, the manufacturers of products who may be polluting the environment have an interest in constructing their waste disposal methods as not risky by using data from scientists that show the chemical they are disposing of does not have deleterious effects on living things or the natural environment.

However, risks are not only social constructions. Thus, Beck (1999) argues that risks are hybrid: "Risks are man-made [sic] hybrids. They include and combine politics, ethics, mathematics, mass media, technologies, cultural definitions and perception; and, most important of all, you cannot separate these aspects and 'realities', if you want to understand the cultural and political dynamics of the world risk society," (p. 221). One example that exemplifies Beck's quote is the case of phthalates, a chemical used in many cosmetic products and children's toys. In the early 2000s, the public became concerned about the potentially toxic effects of phthalates on human health because of scientific studies covered in the media that showed that they could cause liver problems in rodents. Although another group of scientists later determined that children's exposure to phthalates was low enough that it would not cause health problems, public pressure led to political support for banning the chemical from those products (Hamilton, 2009). In this case, although scientists did not agree on the toxicity level for humans, the media's coverage led to public concern, which in turn led to political action. This example illustrates the multiplicity of stakeholders in risk construction (the company, scientists,

and the media) and shows how risk construction in the media is an important factor in influencing public action and legislation.

Individualization, Reflexive Modernity, Choice and Reflexivity

Beck argues that one of the consequences of the shift between first modernity (stable nation-states, family structures, secure employment, etc.) and late modernity is individualization. This is a movement that he describes as a sort of "liberation" from family, class and social structure in the West, a process in which people are free to make their own life plans[viii] and thus are, in a sense, free agents in the global labor market. Beck's individualization may also be understood as neoliberal, "Neo-liberalism is a form of rule which involves creating a sphere of freedom for subjects so that they are able to exercise a regulated autonomy" (Petersen, 1997, p. 194). Within neoliberalism, this tends to focus on an individual as an entrepreneurial subject, free to exercise autonomy within the market. This ideology also tends to de-legitimize the need for social services by emphasizing personal success and failure, while obscuring the structural relations that enable and constrain personal actions (Vavrus, 2002).

Beck argues that because of the loss of the metanarratives of progress that were essential to first modernity, the assumptions of modernity (a set social structure emphasized familial bonds, the relative stability of institutions, such as the authority of the state, and truth claims generated by science, such as the acceptance of objectivity to the exclusion of contingent factors, among others) are called into question by both experts and lay people (this process he terms reflexive modernity). In the following

section, I elaborate each term in-depth (although they function together so their descriptions overlap to a certain extent).

Reflexive Modernity

Beck argues that as a result of both experts and lay people questioning many previously taken for granted assumptions about social, political, and economic life, the position of experts (such as scientists) is precarious: they are needed to construct knowledge about risks, yet the public is skeptical of institutional authority (including doctors and the medical establishment). Beck traces this skepticism of science and authority to the early twentieth century when intellectual threads such as ideology critique and fallibilism (or the idea that science is not the sole arbiter of "Truth") in the theory of science emerged, using science's assumptions of objectivity and the contingency of truth against itself to question the truth claims produced by science. In addition, scientific developments such as the creation of the nuclear bomb revealed that even as science promised progress, it also revealed its possibly disastrous negative consequences (Beck, 1992, p. 156).

I argue that this skepticism of institutional authority—science in particular—points to one reason CAM is experiencing popularity at this time:

> In the United States, scandals regarding FDA-approved drugs have made the public leery of the link between business and health care. Researchers report that both those with and those without health insurance are increasingly turning to alternative medicine or supplements to treat their own illnesses. Patients with

> chronic illness often research their diseases online to educate their physicians about alternative therapies (Wiley, 2008, p. 2).

Lupton echoes this sentiment, "In a climate where concerns about iatrogenic disease, the self-serving financial interests of orthodox doctors and the high costs of medical technology have been placed prominently on the agenda for public discussion, alternative therapies appear a refreshing and radical alternative which offers a sensitive, caring attitude and personal contact with healers" (1994, p. 125). Thus the public's interest in CAM may be attributed in part to the tendencies of reflexive modernity. The critique of institutions also fits clearly with the concept of individualization because if people are free to construct their own life plans, they must also question how institutions function in the interest (or not) of fulfilling that plan. Foucault (1976) along with Rose (2001) terms this reflexive approach care of the self, or a form of self-governance; however, I will be using Beck's concept of reflexivity more extensively as a way to illustrate that critiques of these institutions are not just about self-management, but importantly, are also about the desire for social change[ix].

Individualization

Public skepticism of scientific knowledge in late modernity[x] means that people no longer unquestioningly rely on expert advice. In late modernity, Beck (1992) argues that people are required to make individual decisions about their life path, including job, relationship, and other personal choices that are less dependent on the past strictures of loyalty to one's family, employer, or other dominant institutions, such as medicine. This emphasis

on an individual making choices without the necessity of consulting others, and with only their own future in mind, is what Beck (1992) terms individualization, a "'categorical shift' in the relation between the individual and society," (p. 127) characterized by three general factors: 1) liberation (or not being constrained by social conventions), 2) loss of stability (or no longer being able to rely on concrete knowledge and norms[xi]), and 3) reintegration (or a new social commitment to the individual). To exemplify each point, Beck provides examples of this shift beginning with the loss of status-based classes (such as the European bourgeoisie) at the beginning of the twentieth century, the women's movement (liberation), the loss of traditional forms of family for the middle classes[xii], and the flexibility of work hours and decentralization of work sites (loss of stability). All of these trends, he argues, are dependent on the post-war labor market:

> The individual situations that come into existence are thoroughly *dependent on the labor market*. They are, so to speak, the extension of market dependency into every corner of (earning a) living, they are its late result in the welfare state phase. They arise in the *fully established* market and labor market society, which barely remembers traditional possibilities of support any longer, if at all (Beck, 1992, p. 130).

Beck's individualization thesis directly reflects the neoliberal turn in Western society that emphasizes personal responsibility over institutional safeguards: "Neo-liberalism calls upon the individual to enter into the process of his or her own self-governance through processes of endless self-examination, self-care and self-improvement" (Petersen, 1997,

p. 194). Although the emphasis on an individual creating their own life plan is one of the central tenets of individualization, Beck's thesis differs slightly from the idea that individuals are required to rely solely on their own entrepreneurial qualities to succeed because he also argues that the dependency of the individual on the labor market has resulted in *greater* institutional dependency than in the past:

> The liberated individuals become dependent on the labor market and *because of that*, dependent on education, consumption, welfare state regulations and support, traffic planning, consumer supplies, and on possibilities and fashions in medical, psychological and pedagogical counseling and care. This all points to the *institution-dependent control structure* of individual situations. Individualization becomes the *most advanced* form of societalization dependent on the market, law, education and so on (Beck, 1992, p. 131).

Therefore, in Beck's conception of individualization, people are compelled to actively make decisions about career paths, relationships, and any other number of personal life choices, but they are, due to lack of traditional social support, dependent on social institutions to help them achieve these goals (Rose, 2007 makes a similar assertion). This is an important point because it shows that discourse between individuals and institutions is dialectical. For example, in the realm of women's health, feminist health activists since the 1960s have succeeded in shaping the medical agenda. The establishment of the Office on Women's Health, created in 1991, and a part of the U.S. Department of Health and Human Services, illustrates that women's health has become an important issue in

mainstream medicine and health policy, yet doctors writing in the medical and scientific journals I analyze still circulate ideas that reinforce patient compliance and ignorance, thus reinforcing the assumptions that played a large role in women's historical subordination within medicine.

In *Discipline and Punish*, Foucault uses individualization somewhat differently. He theorized a process of individualization achieved through the examination, where individuals came into being or were able to be known through this process. Foucault described the examination as an important development in the exercise of power across varying social sites including the prison, school, and modern hospital:

> The examination as the fixing, at once ritual and 'scientific', of individual differences, as the pinning down of each individual in his [sic] own particularity…clearly indicates the appearance of a new modality of power in which each individual receives as his status his own individuality, and in which he is linked by his status to the features, the measurements, the gaps, the 'marks' that characterize him and make him a 'case' (1977, p. 192).

Foucault's thesis of individualization, which he argues contributes to normalization, has been well documented in critical examinations of health. Rather than elaborate on those here, I discuss Foucault's concept of individualization because it contributes to an understanding of how medical discourse serves to normalize a standard image of what a healthy female body should look like, and as I will argue in chapter three, this includes a slim, youthful, and oftentimes conventionally attractive person. In chapter three, I will

argue that the examination is constructed by women's popular health media as a means of self-surveillance that contributes to this normalization.

Choice

Choice is a concept that feminist scholars have elaborated both in sociological investigations of health ethics (Sherwin et. al., 1998) and in feminist theory that explores its problematic aspects in a society that increasingly places blame on individuals for making poor choices (McRobbie, 2009 and Baker, 2010). For example, McRobbie (2009) advances a theory that she terms "female individualization," as a means to discuss how individualization leads to an emphasis on individual blame and obfuscates the patriarchal biases in society that weakens the solidarity between young women and older feminists. As she notes in her discussion of female individualization:

> Individuals must now choose the kind of life they want to live. Girls must have a life-plan. They must become more reflexive in regard to every aspect of their lives, from making the right choice in marriage, to taking responsibility for their own working lives and not being dependent on a job for life or on the stable and reliable operations of a large scale bureaucracy, which in the past would have allocated its employees specific, and possibly unchanging, roles…Beck and Giddens are quite inattentive to the regulative dimensions of the popular discourses of personal choice and self improvement. (McRobbie, 2009, p. 19)

I agree with McRobbie's criticism that Beck does not sufficiently attend to popular culture or gender in his analysis (Brannen & Nilsen, 2005 make a similar assertion), so

my project helps elaborate his work with attention to these issues. However, Beck does acknowledge the increasing difficulty of making the "right" choice in an era of competing expert knowledge claims, when experts (such as scientists) may come to opposite conclusions about the same issue (Beck, 1992, and McKechnie & Davies, 1999). In addition, as I noted above, he also grants institutions a great amount of power in determining individuals' achievement of their life plans, and thus does account for the influence of social structure (though I agree he does not take this quite far enough).

McRobbie (2005) also critiques the individualization thesis for not adequately addressing how to forge linkages between classes to achieve social change. For example, in her discussion of contemporary imperatives for middle-class, Western, young women to succeed in education and the labor force, she argues that the focus on individual success encourages them to ignore the barriers of working-class and/or non-Western women who often have a more difficult time achieving these goals. McRobbie's criticism of Beck's inattention to class is valid. Yet, Beck also argues that reflexive modernity is marked by a deep criticism of institutional and social rules. I argue that this criticism also extends to the differences in opportunity between classes (this topic frequently comes up in education reform debates); thus, Beck provides a vision of how progress may be achieved in the risk society (even within a neoliberal context), "Only when medicine opposes medicine, nuclear physics opposes nuclear physics, human genetics opposes human genetics or information technology opposes information technology can the future that is being brewed up in the test-tube become intelligible and evaluable for the outside world," (Beck, 1992, p. 234). In other words, Beck (1992) argues that the self-critical

nature of reflexive modernity is how meaningful criticism is taken into account in order to transform social institutions and politics. Now that I have outlined reflexive modernity and individualization, I will more fully elaborate Beck's reflexivity thesis.

Reflexivity

Beck (1992, 1999) argues that the process of individualization in late modernity leads to reflexivity by both institutions and the public. He suggests that because of competing knowledge claims about risks created by different experts, lay people must constantly question experts' political motivations. This is necessary because Beck argues that in late modernity people have become aware of the contradictory nature of expert knowledge:

> Here is one of the reasons why risk societies can become *self-critical* societies. Different agencies and actors, for example, managers of chemical industries and insurance experts contradict each other. Technicians argue that: 'there is no risk', while the insurers refuse insurance because the risks are too high. A similar debate is currently taking place within the realm of genetically engineered food. (Beck, 1999, p. 218)

What Beck is pointing to here is that the proliferation of risk discourses and the varying stakeholders in the construction of risks have different agendas, and at times, these agendas conflict with public interest. For instance, in the phthalate example, the plastic producers do not want risks to be found with the chemical since that will mean spending time and money to find a different chemical to include in their products; thus they use scientific evidence that shows phthalates cause no harm in humans. On the other hand,

parents of children who have had serious childhood illnesses look for explanations for the disease, perhaps researching environmental causes of illness and determining that studies conducted by scientists that show phthalates cause health problems in humans are accurate. The public's interest usually leans to being exposed to as little environmental health risks as possible. Therefore, they will tend to err on the side of wanting more chemical regulations. Regardless of the "real" nature of the risks of phthalates, public pressure did change legislation, thus illustrating how reflexivity may function in the service of social change in the neoliberal risk society.

However, reflexivity is not a panacea when it comes to challenging the status quo (Kerr & Cunningham-Burley, 2000). For example, as Kerr and Cunningham-Burley point out (2000), reflexivity may be used by institutions to bolster authority and minimize any outside interference. In chapter two, I use their critique to help explain how the medical institution uses reflexivity to secure institutional norms and forestall change. In addition, it is not possible to understand in advance the outcomes of reflexivity. For example, stories on medical errors may lead to an increased in doctor's and patient's emphasis on evidence-based medicine[xiii]; I argue in chapter two that this sequence forecloses other ways of seeing health and illness.

Yet, following Dutta and de Souza (2008) I argue that reflexivity should be considered both a framework and a tool used to question how practices may work in the service of domination because it allows for the constant envisioning of alternatives: "In a reflexive sense, the task of criticism is never really complete; the grand narrative never

comes to closure, as we continuously question the ways in which our practices serve hegemonic interests" (Dutta & de Souza, 2008, p. 329). In other words, a theoretical engagement with reflexivity is constructive because it provides an example of how social change can be achieved within the existing social framework. Reflexivity, as Dutta and de Souza point out, should always also be self-critical, and used to question its own assumptions. This will be imperative to my analysis as I show some of the ways in which reflexivity functions negatively: in chapter two how it is used by physicians to set the terms of debate about the acceptability of CAM using the randomized controlled trial (RCT); in chapter three, how reflexivity is used by the media to acknowledge and then coopt women's unease with unrealistic beauty standards; and in chapter four, how Dr. Oz uses reflexivity to sell his brand at the same time his public critiques of conventional medicine downplay the patriarchal elements of his show.

Rationale/Justification for Study

Using risk, individualization, choice, and reflexivity as theoretical tools for analyzing the discursive construction of CAM in medical journals and in women's popular health media is an important project because risk is a major trope of contemporary health discourse (Nettleton & Burrows, 1995, and Petersen & Bunton, 1997)—particularly women's health discourse (Dubrwiny, 2013); analyzing how risk is used in the ideological construction of CAM is imperative to understanding how it functions both in gender oppression as well as in constructing resistance to how problematic assumptions about women's health are portrayed in the media. While many feminist health scholars

have discussed how risk is used in constructions of women's health (Dubrwiny, 2013, Inhorn & Whittle, 2001, Robertson, 2001, and Ruhl, 1999), there has been insufficient attention paid to how medical journals' constructions of risk work dialectically with popular media to construct women in relation to medical doctors. In addition, there has been scant work on CAM in critical/cultural health communication studies.

Utilizing reflexivity as a theoretical framework is helpful for theorizing social resistance, which can lead to the improvement of women's health, a goal that Annandale (2009) claims is often overlooked by feminist analyses that deal with health through theories of the body: "the fault lines between feminist theory and health and illness are particularly stark. It is common enough to refer to developing 'theory through the body'…, but the body in question is rarely anchored in vital matters of life and death" (Annandale, 2009, p. 3). Following Annandale, I argue that it is consequential to consider how the construction of health in women's popular health media and by medical professionals has material consequences for women's health. For example, Dubriwny (2013) argues that media discourses about women's health may help women construct identities or coherent narratives of their own experiences based partially on those representations. Williams and Calnan also (1996) highlight the importance of reflexivity in late modernity in challenging some of the assumptions of dominant and powerful institutions such as medicine[xiv]: "It is in this context that lay views towards science and technology, including modern medicine, come to comprise a shifting dialectic of trust and doubt, certainty and uncertainty, reverence and disillusionment" (p. 1613). Through reflexivity then, dominant institutions that have traditionally oppressed women, such as

allopathic medicine, may be challenged. My study provides specific examples of how reflexivity is showcased in the media in ways that illustrate how resistance to conventional medicine is articulated[xv] I identify instances both when it works and when it does not.

It is also important to study how the *media* construct risks: in late modernity experience is increasingly mediated (Beck 1992, Williams & Calnan, 1996) and the media often emphasize risks in their coverage of health stories (for example in stories on medical errors and how undergoing a medical process, such as surgery, may cause illness) (Seale, 2002). The media also help to constitute the "field of meanings" that are dominant in any given culture (Hall, 1977) and this is no different for health. In his discussion of the importance of the media in providing available narratives from which people make meaning about health, Seale (2002) notes:

> Perhaps the greatest repository of stories in late modern societies is made up from the various organs of the mass media—television, newspapers, magazines, radio and, increasingly, the Internet. Here, people find a rich collection of resources to draw upon in telling the story of their selves. When people get sick, or make decisions about health, or visit their health service providers, or decide what to think and vote about health care policy and finance, their behavior may be formulated in large part from resources drawn from various mass media (p. 2).

Health information presented in the media therefore helps to establish what counts as good or bad health for women and may also influence what medical treatments they pursue. As Lupton (1994) points out:

> The mass media are important in portraying medicine, health care, disease, illness and health risks in certain ways, from the soap opera's kindly doctor to the news bulletin's account of medical miracles, contributing to people's understanding of these phenomena, especially when they have little or no direct experience of them (p. 17).

Furthermore, the media play a significant role in the social construction of risk: "Whether rejected, accepted, or modified, comments by expert risk definers contained in news accounts serve as points of departure for personal conversations" (Stallings, 1990, p. 81). Stallings and Seale (2002) also illustrate that media perspectives are multiple, reflecting the views of varying stakeholders. Seale (2002) for example, discusses how corporations such as pharmaceutical companies use the media to target consumers by encouraging them to ask their doctors for their products. Yet, as both Stallings and Beck note, the media do not determine in advance the political outcomes of their coverage: "risk is not the *outcome* of media and public discourse, but exists *in and through* processes of discourse" (Stallings, 1990, p. 82). Therefore, analyzing specific media, including major medical journals, allows a more focused reading of how risk is constructed in health discourses in specific media sites. Analyzing these discursive constructions and tracing

the increasing influence of CAM on conventional medicine will help illuminate how the media have contributed to the current popularity of CAM.

Not only do the media help construct what counts as health, analyzing health discourse in the media is important because the public views the media as credible sources of health information (Friedman, 2004). In a 1998 nationwide poll conducted by the National Health Council, 40% of those polled cited television as their primary source of health information, leading doctors by almost 5%. In addition, almost 60% of people changed their behavior or took action because of a health story from the media and 42% looked for more information based on a health story in the media (Friedman, 2004, p. 2-3). Popular media, such as talk shows, are also instructive about health. In his study of entertainment-education media (or the placement of educational messages in entertainment content), Dutta (2007) found that those who watched health-oriented talk shows became more interested in health after watching the shows; this will be important to my study since I am analyzing the health talk program, *The Dr. Oz Show*. In addition, media coverage of health risks, such as the supposed risks of childhood vaccinations, may have implications for public health (Ratzan, 2004). Therefore, it is pertinent to interrogate how the media presents health information and which health stories they choose to cover because their selection illustrates which health risks are considered worthy of attention, thus uncovering which ideological beliefs about illness and health are being most widely circulated.

Lastly, the media are important objects of study because they can be vehicles for social change (Beck, 1992). As Beck (1992) notes, "the consequence for politics is that reports on discoveries of toxins in refuse dumps, if catapulted overnight into the headlines, change the political agenda" (p. 197). While Beck's claim of the power of the media may be overstated, his point that the media are integral parts of contemporary social change is a valuable insight. Because the media have become important platforms utilized by politicians, business people, and scientists in order to get their viewpoints across to the public, they function in some ways to convey expert opinions. However, despite their ability to be used by powerful stakeholders, popular media also provide coverage that identifies institutions and corporations as sources of risk (Beck, 1992), oftentimes featuring stories about how, for example doctors make medical mistakes.

The importance of media I outlined above extends to women's popular health media. I proceed with this project cautiously, keeping in mind, as Green, Thompson and Griffiths (2002) point out, that "women" must not be a category abstractly applied to all women at all times; instead, how women make health decisions should be considered historically and contextually. And of course, women are not a homogenous group but embodied individuals with a range of experiences. I am limiting my scope primarily to North American, middle-class, educated women (as they are the group using CAM most frequently)[xvi]. In addition, health discourses that rely heavily on risk may be targeted toward white middle-class women most because they are less subject to overt state control than low-income women (through, for example, subsidized housing or welfare programs). "Indeed, it is precisely well-educated, white, middle-class women who most

fervently endorse what I refer to as 'the individualized risk[xvii]' model of pregnancy and birth. This characterizies risk society in general, and holds true when specific sub-groups, in this case women, are implicated" (Ruhl, 1999, p. 112). Ruhl essentially argues that white, middle-class women voluntarily subscribe to risk mediation activities during pregnancy (such as caffeine restriction), but that the ideology of individual risk mediation in the prenatal context can be problematic. For example, when doctors imply that women who follow their advice will have healthy babies, women may feel shame or distress if they follow all the rules and still have a child with a health problem.

In addition, as Lupton (1994) suggests, middle-class norms of appearance and demeanor (she places these in the context of Bourdieu's habitus) emphasize youthfulness and slimness more than do the norms of appearance for working-class women. Thus, she argues middle-class women typically participate in exercise and weight-reduction activities more than working class women do (p. 40). Because of the white, middle-class women assumed to be the CAM consumer and the individualistic focus on health empowerment that permeates media constructions of risk, the discourses about CAM targeted towards this group of women are in a sense postfeminist at the same time they are neoliberal. Indeed, as Vavrus (2012) notes, one of the reasons that postfeminism and neoliberalism are compatible as ideologies is that they emphasize individualism to the exclusion of social action. This will be important in chapter three, where I discuss the articulation between beauty, slimness, and health in women's popular health media.

Rationale for Media Selection

Popular health media do not feature medical stories arbitrarily, but have a symbiotic relationship with medical journals (Friedman, 2004). For example, medical journals often preview important articles for media outlets before they are published and medical researchers view the media as important sources of information. One study found that articles from *The New England Journal of Medicine* that were covered in *The New York Times* were cited 72.8 % more in other medical journal articles after being featured in the media (Friedman, 2004, p. 3). Considering the symbiotic relationship between medical journals and the media illustrates that popular media such as newspapers, magazines, and television programs exist in a structurally meaningful relationship to medical journals, rather than serving as mere channels through which medical messages are transmitted. Because the media often glean health information from medical journals, it is important to analyze the discourses of both sites in order to understand how they work together in a mutually constitutive fashion. For example, as I discuss further in chapter four, some of the doctors who express criticism about CAM in the medical journals I analyze also discuss Dr. Oz in news stories or appear on his show to defend their positions.

In this dissertation, I analyze both popular media sources—*The Dr. Oz Show*, *Women's Health* and *Prevention* magazines—and opinion pieces in biomedical journals, specifically *The Journal of the American Medical Association (JAMA), The New England Journal of Medicine (NEJM), Science* and *Nature*. I chose the *Dr. Oz Show* because, as I will discuss in chapter four, Dr. Oz has become one of popular culture's most credible

sources of health information. I focus primarily on his television program because of the limited scope of this project, which would be unable to account for his vast media presence in conjunction with the rest of my empirical materials. In addition, television is where he began his career in media and serves as the hub in the mediated empire he has created.

Another reason I analyze *The Dr. Oz Show* is because of his relationship to the women's health magazines I analyze. These two media sites may share a more interconnected audience than his other media platforms. "It helps that his [Dr. Oz] television viewers also read magazines. His show attracts a following of women aged 25 to 54 who are, according to one study, 126 percent more likely than the average person to read women's magazines" (Haughney, 2012). In addition, Oz helps to sell magazines such as *Women's Health* on his television program (for example, by featuring an editor from the magazine on the show), an indispensable benefit to publishers who are facing increasing difficulties finding cover stars who will help sell magazines. Dr. Oz is currently one of the most popular magazine cover stars, and is the first man to appear on four women's magazine covers (Haughney, 2012).This is relevant because as I will discuss in chapter four, the presence of a shared audience base is also important to the expansion of Oz's brand, which he links closely with CAM.

In addition, women's health magazines are important to analyze because as health scholar Stephanie Roy (2008) notes, they are a unique source of health information, blending anecdotes with studies from medical journals; feminist health educators have

also found women's magazines to be an effective means to promote safe sexual practices among women (McRobbie, 1997). Finally, college women who read health and fitness magazines were more likely to be concerned with body size and shape than those who read fashion magazines (Thomsen, 2002, p. 1000). The sum of research indicates that women's magazines offer useful health information to readers as well as shape how they view body size, an important element to consider given the conflation of beauty with health that I describe in chapter three.

I chose *Prevention* and *Women's Health* magazines for different reasons. First, *Prevention's* circulation was significantly higher than any other women's health and wellness publication. In 2011, *The Huffington Post,* using data from the Audit Bureau of Circulation, ranked the 20 most popular magazines for the first half of 2011; *Prevention* ranked sixth overall. This is significant because the list included both woman-targeted publications such as *Oprah* and *Family Circle,* as well as publications targeted toward men such as *Maxim* and *Sports Illustrated*. Notably, it was the only women's health and wellness magazine on the list. In addition, when Dr. Oz was featured on *Prevention's* 2012 cover, sales increased 45 percent from the year before (Haughney, 2012). I chose *Women's Health* magazine (*WH),* because it was one of only three magazines with a wide circulation (including *FamilyFun* [a family oriented magazine] and *People StyleWatch* [a celebrity magazine]), which increased the last half of 2009 (overall magazine subscriptions and newsstand sales were down over 9% its circulation increased 21.5%). This is significant because like *Prevention, WH* fared well among *all* magazines, not just those that were targeted to women or health-focused (Clifford, 2010).

Both *Prevention* and *WH* frame CAM as a valid means to promote health or treat minor ailments. The coverage in both magazines is also mainly supportive of CAM therapies, though they often cover therapies that are acceptable in the allopathic medical community (which include using CAM for pain management). However, in 2011 both magazines featured articles that explored the placebo effect and provided a critique of science-based medicine that I would consider feminist for the respect it showed for women's subjective experiences of health. For example, *Prevention* profiles a woman's personal experiences with CAM use (acupuncture) and validates the woman's experience of pain, situating allopathic medicine as unable to provide her with an adequate solution.

Literature Review

One of the difficulties with my project is that it is engaging with interdisciplinary scholarship, a feature that makes limiting my literature review very difficult. As Lupton (1994) notes, "An interdisciplinary perspective, while exciting and stimulating in its breadth, poses its own problems. When one is integrating research and scholarship from a number of disciplines, it can be very difficult to know where to draw the boundaries" (p. 2). With that in mind I have organized this review to include, first, a broad look at why critical/cultural health communication is important and next, to provide a review of scholarship that has engaged with critical analyses of media and health. This survey will not be exhaustive but is representative of the type of work that is currently being done in the field. Lastly, I provide specific literature that applies my chosen analytical concepts: risk, individualization, choice, and reflexivity to health and gender.

Much of current critical/cultural health communication has been informed by the work of M.J. Dutta (2010), a scholar who has interrogated the rationale, methodology, and assumptions guiding health campaigns in non-Western countries, such as India. Other communication scholars such as Zoller (2005) interrogate how health activism should be critically analyzed to see how health activism movements are influenced by power and inequality. Both Dutta's and Zoller's analyses highlight the importance of analyzing power and ideology in the study of health communication. My project asks similar questions about power and ideology but adds to the literature because it takes a different theoretical approach by incorporating Beck's risk society thesis. In addition, my research includes the perspectives of medical doctors: this is different from most work that has been done in critical/cultural health communication studies, which has not sufficiently attended to the opinions of medical doctors.

My work also adds to feminist health literature on choice. The current feminist scholarship on choice in the health context[xviii] primarily addresses how women's health suffers in the context of neoliberalism. For example, Lippmann (1999) argues that the expansion of consumer health care choices does not meaningfully improve women's health[xix] but merely expands consumer options, while Robertson (2000) argues that risk mediation tends to be discussed in terms of individual solutions to illness (such as diet and exercise) to the exclusion of social causes, such as environmental pollution, thus emphasizing individuality and limiting the likelihood that social movements designed to challenge social causes of illness will be organized. Similarly, Dubrwiny (2013) points to the rhetoric of choice as a significant contributor to an emphasis on individualism within

women's health discourses. I use Lippmann's (1999), Robertson's (2000), and Dubrwiny's (2013) work and extend their critiques to argue that the neoliberal tendencies they identify are occasionally challenged in women's popular health media through the media's reflexivity.

Other feminist scholarship on choice in health-decision making critically assesses the concept of informed consent in bioethics to argue that women's decision-making in health should be considered more complexly with attention to how women's choices are made contextually and imbricated in unequal power relations (Sherwin, et. al., 1998). I add to the feminist literature on choice, because like Dubriwny (2013), I include the media as influences on how women make choices about health and which decisions they see as viable.

My work will also add to the literature on women's health and risk. The current body of scholarship tends to focus on how the discourse of risk serves a disciplinary function, for example in how it regulates women's health behaviors in prenatal care (Ruhl, 1999). Dubrwiny (2013) also analyzes risk discourses. In her example, she argues that the public and advertising discourse about the Gardasil vaccine used risk to suggest that girls were both vulnerable (because they needed to be protected from the risks of sex) at the same time they were empowered (by being able to reduce the risk of cervical cancer by receiving the vaccine). My dissertation adds to the literature because I use Foucault's concepts of discipline and biopower to complement my theoretical perspective, which deeply engages the work of Beck rather than uses it as a starting point

for critique. My project also provides an in-depth study on how the media influence, and are shaped by, prevailing discourses on risk in the health context. Finally, my project offers a comprehensive look at how CAM is discursively constructed by women's health media and medical journals, a project that has not been undertaken in critical/cultural health communication.

Critical/Cultural Approaches to Health Communication

Deborah Lupton's (1994) germinal article on critical analyses of health communication explores the importance of discourse as an element structuring how health information is presented. "*Discourse*, in this usage, can be described as a pattern of words, figures of speech, concepts, values, and symbols that is organized around a particular object or issue and that can be located in wider historical, political, and social processes and practices" (Lupton, 1994, p. 61). Her article explores the importance of critical/cultural studies to the application of health, arguing that health is not a neutral term must therefore be examined for how it is being used and to what ends. For example, she points out the historical tendency in health communication research in studying compliance in health campaigns and argues that these studies tend to neglect the power differentials and cultural contexts between health officials and their target populations. Her article opened up the field of critical/cultural health communication by asking questions about the discursive construction of health, arguing that health is not a simple or straightforward concept, but is a cultural construction.

Following her work, Dutta has been an important influence in the field. Dutta's (2010) article, "The Critical Cultural Turn in Health Communication: Reflexivity, Solidarity, and Praxis," addresses four assumptions made in traditional health communication scholarship that have subsequently been challenged by critical-cultural health communication scholarship: 1) assumptions of universality that rely primarily on Western understandings of science and healing (Dutta points out that the ways in which healing is understood is intricately connected with value systems that are often not acknowledged by public health officials seeking to meet health outcomes); 2) assumptions of effectiveness that ignore social and cultural barriers (such as poverty) to the achievement of health goals, the sustainability of public health interventions, and the political and economic structures that influence public health campaigns; 3) assumptions of innovation that fail to understand how "innovations" are understood in various cultures as well as fail to recognize the political and economic implications for how interventions are framed to varying target populations (Dutta explains that a goal for critical/cultural health communication scholars is to make sure that community members are active participants in assessing the value and need for health interventions within their communities); and 4) assumptions of criteria that question how grants for public health initiatives are selected (for example, why might a grant for reducing obesity in poor urban areas be selected over other projects?), what questions or goals are determined as criteria for these campaigns, and how are those questions or goals imbricated in unequal power relations. Dutta's first two assumptions (of universality and effectiveness) underlie the point I make in chapter two about the universality of scientific methodologies and the

medical journals' and media's erasure of social and structural influences on health. Now that I have surveyed why critical/cultural work in health communication is important, I briefly outline the critical/cultural scholarship that has addressed health discourse in the media and medical journals.

Dubriwny's (2013) book *The Vulnerable Empowered Woman: Feminism, Postfeminism, and Women's Health*, provides an insightful look at how narratives about women's health are constructed in the media. She argues that current narratives about women's health emphasize postfeminism and neoliberalism to the near exclusion of discourses of collective empowerment and the critique of medicine that was a part of the women's health movement. She claims that these narratives result in a "vulnerable empowered" (p. 8) woman, one who is constructed as autonomous through making health choices, such as exercising but who is also vulnerable to all manner of health problems. She highlights the dominance of risk as an organizing principle in health discourses targeted to women, though she takes a slightly different approach than I do. Dubrwiny does not engage with Beck's risk society thesis; instead, she uses the work of Foucault to understand risk as a rationality: "I understand risk through a governmentality perspective that draws from the work of Michel Foucault in which risk becomes a practice, technique, or rationality through which governing is accomplished and authority is exercised" (p. 27). There are two main reasons I do not use Foucault's governmentality thesis to explain risk: first, Dubriwny, as well as other health scholars[xx] have already done a quite thorough job of incorporating his work in the study of health and risk; second, I want to theorize agency (or reflexivity), so that I could think through how popular resistance is

working to temper the negative implications of risk discourses discussed by the scholars above. I am not arguing that Foucault's theories have been exhausted in relation to risk and gender in the health context (I will be using some of his theories to explicate my points), but given that there are already very good examples of this work, using his work to complement Beck's theory could help broaden the theoretical approaches to the topic, thus contributing to a richer understanding of how risk discourses function in women's health. In addition, while I wholeheartedly agree with Dubriwny's take on risk discourses being deployed to emphasize neoliberal, postfeminist principles, I also discuss risk in the context of how the media construct medical institutions and doctors as risky, thus contributing to reflexivity within contemporary medicine.

Literature that takes a Critical Approach to Health in the Media and Medical Journals

In their essay of interpretive frameworks of medical news in the British media, Entwistle and Sheldon (1999) provide a comprehensive look at how health and media scholars have identified major interpretive frameworks for news coverage of health stories since the 1970s. They discuss the work of Karpf (1988) as providing, during the 1980s, an important framework for categorizing how health news was presented. Karpf provides four main categories of this coverage—including the medical approach—which idolizes the potential of modern medicine, the consumer approach, which posits a conflict between the power of the doctor and the interests of the patient; the look-after-yourself approach, which emphasizes individual decision-making in health; and the environmental

approach, which highlights the environmental and social causes of illness. My analysis shows that Karpf's frameworks still hold true, especially the latter three.

Next, Entwistle and Sheldon survey the work of Bury and Gabe (1994), whose scholarship is important for my study because it provides an example of how the mass media actively participate in the critique of conventional medicine. For example, Bury and Gabe analyzed news stories that critiqued pharmaceutical companies for producing Lorazepam (a potentially addictive drug used for treating anxiety) and blamed physicians for overprescribing the medication while not providing assistance to patients who were trying to stop taking it. Bury and Gabe's work illustrates that the mass media have participated in such questioning of the medical establishment since at least the 1990s; this will be important to my analysis because I revisit in chapter four how the media participate in questioning the allopathic medical community.

Following their survey of Bury and Gabe's work, Entwistle and Sheldon conclude that the power and prestige of doctors and medical institutions is now routinely called into question by the media and argue this has partially given rise to evidence-based medicine (a trend that I argue in the next chapter is not conducive to testing CAM therapies). This is an important point, given that I am analyzing how reflexivity in the media may lead to institutional changes within conventional medicine. In their example, they argue that critique of medicine by the media (reflexivity) has influenced health research (or the increasing importance of evidence-based medicine) in order to partially

assuage public critique of conventional care. This example also illustrates that the outcomes of reflexivity may not necessarily result in positive social change.

In his edited collection, *Media and Health*, Clive Seale (2004) brings together the scholarship of sociologists of health and media studies in order to address the question of "how cultures construct personal experiences of illness and health" (Seale, 2004, p. ix). Among other topics, the book addresses how the media construct health by using certain frames, such as victim/villain scenarios. Seale's book is important to my project because one of the frames he identifies is, "the dangers of modern life" (p. 9). Although he doesn't use the term risk, his summation of this category is that it emphasizes the risks of everyday life, such as genetically modified (GM) foods, environmental pollution, and contraceptive pill scares, among others, thus illustrating how risk is one of the important constructs in how health is discussed in the news media.

Seale also identifies the need for medical sociologists and media scholars to work together and provides some good examples of how the media help to construct people's understanding of disease. One particularly interesting example in this edited collection is Kroll-Smith's (2004) article on how excessive daytime sleepiness has been constituted as a disease by the media. Kroll-Smith argues the media help construct lay experiences of disease as real, even if they fall outside the bounds of what is considered real by institutional medicine. This is important to my analysis because many symptoms that are not considered "real" diseases or afflictions by the medical profession, such as fibromyalgia, affect women disproportionately, thus illustrating both a diagnostic bias

toward women patients and how the media may validate patients' subjective experiences of illness (I discuss this extensively in chapter four).

In chapter four I also analyze how Dr. Oz constructs his brand. To fully understand how Oz is successful at constructing his persona as a caring, sympathetic, doctor it is important to consider how doctors have historically been portrayed on television. Thus, the work of Joseph Turow (1989) on the history of how doctors and the medical establishment have been portrayed on television is valuable because it provides insight into cultural mythologies about doctors. Turow analyzed shows such as *M*A*S*H* and *ER*, and argued that among other elements, television shows tended to portray doctors as heroic while ignoring institutional inequities by making health care seem as if it is free and accessible to all.

Finally, Lester Friedman's (2004) edited collection on medicine and the media brings together the work of critical/cultural scholars of health communication and the media, providing a broad survey of different media forms such as print media, ads, film, and television with a look at how the media help construct meaning about medicine, a question that I also interrogate throughout this dissertation.

In my survey of the literature, I located just one article that analyzed medical journals from a discursive perspective. In his analysis of how often the term "risk" was used in medical journals, Skolbekken (1995) argues that though the life expectancy rate is higher in Europe and North America than ever in history, the focus on the risks of everyday life to our health has increased exponentially (1995, p. 291). Skolbekken's

work addresses how the term risk has appeared increasingly in medical journals and how it has become taken-for-granted in healthcare. Based on searches in the Medline database between 1967 and 1991, Skolbekken looked at U.S. (*JAMA*, *NEJM*), British, and Norwegian medical journals to analyze how often the term was used. The term was so pervasive that Skolbekken termed it a "risk epidemic," highlighting how it serves an ideological function in the medical journals:

> The most vital contribution to the "risk epidemic", then, has come from the development of scientific thinking itself. Within this thinking there has been a movement from a paradigm of monocausal determination towards a paradigm of multiple causes and effects, accepting uncertainty as a vital factor (1999, p. 298).

Skolbekken argues that risk calculations may be used by physicians to help people feel as if they have some measure of control over health and illness and to confirm optimism about what can be achieved through science. Among the other implications of the discursive use of "risk" in medical journals are that it expands the healthcare industry (because risk factors for diseases become diseases in themselves and thus worthy of treatment) and it moves medicine more firmly into the realm of science. Among the other criticisms of what he terms "the risk epidemic" in medicine, Skolbekken mentions the possibility that humans are not linear systems and that chaos theory might better be applied to understanding human health. "If we are to believe the epidemiological risk constructions, there seem to be few, if any, things in life that are purely healthy or unhealthy" (p. 302). Finally, Skolbekken highlights the profoundly Western nature of the

risk epidemic: “It [the risk epidemic] is reflecting the socially constructed reality of a particular culture at a particular time in history. In a global and historical context it may be seen as a luxury problem of the richest part of the world” (p. 302). Although I agree with Skolbekken’s assessment that risk discourse works to expand the market for technological medicine, I believe that the interest in CAM represents a small pushback to that expansion. However, the discursive use of risk does expand the market for other health related services, such as CAM therapies. In the next section, I illustrate how the term “risk” is not gender neutral, but is used in health discourses to perpetuate gender inequity in healthcare.

Risk, Health and Gender

Like Chan and Rigakos (2002) I argue that risk is not gender neutral, but instead is inherently gendered. “A recognition of risk as gendered relies on acknowledging that there can be no essential notion of risk; that risk is variable; risk itself is of more than one type. Our argument is that gender is one important constitutive determinant of how risk is negotiated and understood” (p. 756). I argue that many health risks are also gendered. For example, some health topics that rely heavily on risk discourses, such as prenatal health, are experienced only by women, whereas those concerning prostate cancer and the PSA test are experienced only by men.

In her analysis of how pregnant women are regulated by risk and responsibility discourses Ruhl (1999) notes, “Responsibility is equated with the capacity to behave rationally; the term presupposes a calculation of expected benefits and risks, and a

decision to follow the path with the greatest possibility of benefit with the least risk. In this sense, responsibility talk within liberal regimes is also morality talk; behaving responsibly is a moral act" (p. 96). Therefore, when women are unable or unwilling to participate according to the recommended behaviors during pregnancy, they may be subject to self or social critique. As Ruhl (1999) notes, "This conception of health is an extreme departure from more conventional views in which good health is something one is born with; positing health as something that an appropriately motivated individual could achieve, if only they worked hard enough, raises the inevitable question of whose fault it is when illness occurs" (p. 111).

In Ruhl's example, while pregnancy is experienced only by women and is thus gendered in that sense, there is a broader way in which women's individual responsibility for pregnancy has important gendered components. For example, as she points out, oftentimes women are not (even if they wanted to) able to follow the advice in pregnancy manuals. She argues that women are expected by doctors and the medical establishment to be individually responsible for their behavior, while outside factors such as domestic violence and poverty, which affect women more than men, are not taken into account. Although men also experience health advice that emphasizes individualism, as Ruhl points out, the very strict behavioral regulations that pregnancy advice manuals recommend for women before, during, and after pregnancy—including quitting caffeine and alcohol to name just a few—may encompass several years of a woman's life. This sort of extensive self-surveillance is not experienced to the same extent in health recommendations given to otherwise healthy men.

Robertson (2000) makes a similar assertion about how health risks are constructed by the medical community as the responsibility of individual women based on her focus-group interviews that asked about breast cancer risk. In her interviews she found that women identified individual behaviors, such as eating healthfully, not smoking, and limiting alcohol as key components in managing their risk of getting the disease. Although the women interviewed acknowledged the possible environmental causes of disease such as food additives and contaminated water, Robertson points out that the women did not consider collective action to try to change policies as a strategy to lessen risk, partially because of the public health discourse that emphasizes individual behavior as a means to mediate risk. She further argues that risk discourses may serve to make women feel as if they can never be normal or healthy (Linnell, et. al., 2002 and Clarke, et. al., 2010, make a similar assertion). "To the extent that risk represents a warning to the individual of potential future illness, this may become a lived or experienced state of ill health" (Robertson, 2000, p. 222).

As most of the aforementioned feminist scholars argue, risk is gendered in these contexts because the women's health movement (which fought for women's participation in their own health) has been deployed in medical discourse in a neoliberal individualistic context that has, instead of leading to empowerment, contributed to women's self-surveillance (Ruhl, 1999). While men's health discourse is also individualistic, because of the history of women's struggle for rights within the medical context and the subsequent ways in which individual responsibility for health has been sold to women as an example of health empowerment is particularly problematic.

Beck-Gernsheim (2000) similarly argues that responsibility plays a prominent role in the medical discourse about managing health risks (Dubriwny, 2013 makes a similar assertion). Discussing prenatal and genetic testing, she highlights the ways that taking responsibility can easily slide into blaming patients for not doing the "right thing," such as deciding not to give up a child with a disability. In addition, her observation that patients have obligations not just to society, but to other family members, children, and oneself, means that making decisions may affect multiple people in different ways: "The more levels of responsibility, the more sources for reproach, for social and moral pressure, the more potential for blame. This prepares the way for taking the tests. For instance, take those women who are labeled as 'risk group' [in pregnancy] because of their age" (p. 132). Along with highlighting the ideology of individualism in achieving or maintaining health, these articles also reveal the *socially constructed* nature of risk, and foreground gender as an important component in the construction of risk discourses.

In their discussion of the socially constructed nature of risks, Nelkin (1989), and Douglas and Wildavsky (1982), argue that evaluating risk is a social process. For example, there are clearly health risks, but even when those risks are aggregated into numbers or percentages they may still be contested among experts:

> Scientific judgments about risk are often constrained by inadequate evidence, relatively primitive diagnostic techniques, and limited understanding of the mechanisms by which hazards may affect human health. The cumulative and synergistic effects of multiple exposures to combinations of substances are poorly

> documented. Moreover, drugs and chemicals may affect different people in different ways (Nelkin, 1989, p. 98).

Thus, while risks do exist, as Nelkin points out, science is often poorly equipped to make estimations that have a high degree of certainty about how different risks affect any given person. Because risks are ideological, both in how they are gendered in health contexts and in their emphasis on personal responsibility, it is important to analyze how medical institutions as well as media construct risks in order to see what ideologies are in play. Now that I have established the way risk is used in health discourses often relies on individual solutions for maintaining and improving health, I discuss the literature that illustrates how this trend affects women's health more broadly.

The Expansion of Risk Discourses: Implications for Women's Health

In their discussion of the shift from medicalization originally theorized by Irving Zola in 1972 (i.e., aspects of life that do not fall under the category health become subsumed as health problems or issues) to biomedicalization— "the increasingly complex, multisited, multidirectional processes of medicalization that today are being both extended and reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific biomedicine"—Clarke, Shim, Mamo, Fosket and Fishman (2010, p. 47), argue that the biomedicalization of health risks (or the use of technology and science to study, measure and aggregate health risks) leads to increasing surveillance of the public by health officials. They argue that this expansion of surveillance also allows for the more precise calculation of risks, thus creating a cycle of risk construction

that necessitates surveillance in order to mediate risks. As a result of this cycle, they point out that it becomes almost impossible not to be at risk for something, and instead of categorizing populations as risky or non-risky, both individuals and populations are treated by public health officials based on *degrees* of risk (Armstrong, 1995 makes a similar assertion).

Such surveillance, Shim (2010) argues, also leads to targeting certain "high risk" groups as epidemiologically worthy of surveillance (Rose, 2001 makes a similar assertion). For example, some illnesses, such as heart disease, affect racial minorities more than whites, thus legitimating increased surveillance of these groups. In her interviews of those with heart disease, Shim (2010) found that racial minorities often attributed their increased risk of the disease to social causes (such as their lack of access to employment, housing, and discrimination), while epidemiologists tended to conflate race with cultural difference, thus obscuring structural causes.

Some social epidemiologists, however, critique the traditional epidemiological model and believe that social and structural issues factor into disease. For example, among Inhorn and Whittle's (2001) critiques of conventional epidemiologists are those who: 1) blame individuals for health by constructing risk as a lifestyle choice; 2) limit understanding of prevention and disease by ignoring meaning as important to human behavior; 3) do not question social hierarchies; and 4) ignore how a nation's policies affect the health of a nation (p. 554). In order to remedy these shortcomings, Inhorn and Whittle (2001) advance a feminist epistemology that they argue have the potential to

change the assumptions of the field. They suggest that this method includes interrogating the following factors of conventional epidemiology: 1) problem definition and knowledge production in women's health; 2) biological essentialization of women as reproducers; and 3) decontextualizaiton and depoliticization of women's health risks (p. 557)[xxi]. They argue that the *methods* of epidemiology must also be questioned as part of a feminist analysis:

> Today, part of the reason why women's voices continue to be excluded from problem definition and knowledge production has less to do with consolidation of professional power and authority in biomedicine than with disciplinary boundaries and methodological approaches that are exclusionary and continue to divide the intellectual landscape in women's health research (p. 558).

Inhorn and Whittle's work is important to my project because I also interrogate how the dominance of scientific methodologies is used by doctors in medical journals to reinforce traditional models of medicine to the exclusion of alternative methodologies and models, thus limiting the scope of what sort of medical research is conducted and what treatments are considered viable within conventional care.

In her discussion of how risk can help set the agenda for treatment options and research (Fosket, 2010), uses the example of chemoprevention in women at risk for breast cancer and argues that once everyone is constructed as "at risk," risk becomes an informing principle of health research. "Once the idea that everyone is potentially ill becomes part of common discourse, the next step is to determine what the signs or

symptoms of that potential illness might be—risk factors. The tasks of specifying risk factors that might lead to future illnesses then become part of health research" (Fosket, 2010, p. 332). She argues that preventive measures encouraged by health professionals such as eating healthful foods, exercising, and avoiding excessive alcohol as a means to reduce breast cancer risk are unproven, but seen to be an unquestioned good, because they are healthy in general (Fosket, 2010). Yet, this advice may be problematic given that if women fail to follow a "healthy" lifestyle, they may feel blame or social censure if they do become ill. An emphasis on prevention and a healthy lifestyle is also central to the discourses surrounding CAM in the women's popular media that I analyzed. My analysis shows that *The Dr. Oz Show, WH* and *Prevention* conflate diet and exercise with disease prevention, making beauty and fitness desirable side effects of enhanced health; this process thus masks the underlying social imperative that women conform to dominant beauty standards at the same time it imposes a tyranny of guidelines women feel obliged to follow in order to stay healthy. In this sense, then, suggestions about preventive health may serve a somewhat disciplinary function (Rose, 2007).

The above section has illustrated how risk proliferates in health discourse, becomes an informing principle in medical research, and has expanded risk groups to include everyone. At the same time, the expansion of risk also legitimates the close monitoring of those deemed to be high risk—often women and racial minorities. Finally, the solution to risk mediation often forwarded by public health officials has been a focus on individual behaviors rather than social factors, thus obscuring social and structural causes of illness and perpetuating a neoliberal ethos. In the next section, I interrogate the

concepts of responsibility and choice as they are articulated to women's health decision-making and argue they are not simple and straightforward concepts in the context of the risk society.

Choice in Women's Health

"Choice" as it has been conceptualized in women's health has been a central tenet of the women's health movement as well as an important guiding principle of Western biomedical ethics. Both Lippmann (1999) and Giddens (1999) argue that choice is intimately tied to risk. For example, as Giddens (1999) argues, discourses that rely on risk are not just about avoiding hazards but are also about the *expansion* of choice. In the medical context this can be understood as an expansion of medical treatments, therapies, and technologies all of which expand medical options, but do not necessarily lead to patient empowerment (Lippmann, 1999). Dubriwny (2013) has argued that the rhetoric of choice in women's health has been used to enhance neoliberalism rather than assist communal activism:

> Broadly speaking, then, women's health is currently being discussed, researched, and publicized in a cultural context in which all individuals are increasingly held responsible for their own health and well-being; consumption has replaced political action; negotiating risks means taking responsibility for those very risks; and equality is applauded but economic policies continue to reify (and indeed enlarge) disparities in the economic, political, and health conditions of diverse groups. (p. 23-24)

This passage illustrates how the rhetoric of choice in women's health can contribute to the continuation of health disparities between women at the same time it emphasizes individual responsibility—a point that I argue is clearly present in women's popular health media constructions of managing health risks.

In addition, making choices about any given treatment is not generally made using a "rationalist" framework based on probability, but is heavily impacted by social factors and mediated by messages about disease, risk, and probability based on information gleaned from doctors, family members and the media. In this section, I touch on two main difficulties with the concept of choice as empowering: first, I illustrate how autonomy is an illusion in decision-making about healthcare because even when one is in a position of relative social power, the information about health risks are contested and changing; and second, the same health care choices are not equally accessible to all women, thus exacerbating health disparities in women from different social classes.

Autonomy as Illusion

True autonomy in decision-making is never fully possible, given the multiple social and structural factors that influence how individuals make decisions: "This model [freely choosing, autonomous] of choice eschews psychological complexity by refusing to address how power works in and through subjects, not in terms of crude manipulation, but by structuring our sense of self, by constructing particular kinds of subjectivity" (Gill, 2007, p. 76). What Gill points to in this quote is that power shapes and influences personal decision-making in subtle ways. It is not necessarily obvious to the person in

question, but may instead influence what someone feels are the available options, foreclosing some, while advancing others. For example, in a health decision-making context, someone who has never had health insurance might choose very different treatment options for the same condition than an individual who is insured. In addition, just as with anyone else, women are not isolated from the influences of close others. This complicates the understanding of choice as a purely autonomous act:

> There is a tendency in much biomedical literature to locate (all) influences/constraints on choice internally and to assess an individual's knowledge, competence, emotional state, understanding, and so on, as potential, and self-changeable impediments to her ability to choose. But overwhelming any such influences, and generally ignored are powerful external influences and constraints on women's choices, with service availability, relationships with and responsibilities to others prominent among these. (Lippmann, 1999, p. 283)

Lippman's insight is important because it highlights the interconnectedness of women and the varied relationships they have with others in their lives that powerfully factor into individual choices. Therefore, the model of individuality assumed by a rational subject in the biomedical context is fundamentally altered when people are considered relationally (Sherwin & McLeod, 2000). Not only does the assumption of a freely choosing, rational individual fail to recognize the social relationships of women, it glosses over differences in access to similar choices by different women (Lippmann, 1999).

Differential Access to Choice

In the context of healthcare, rational choices about decision-making have usually been reduced to informed consent (Dodds, 2000, and Sherwin, 1998). Yet agency to make choices is never equally distributed among all women, and the ideal of "choice" can function to perpetuate oppression: "seeing choice as gender (class, race or otherwise) neutral hides the operations of power that construct choices, reaffirms existing privileges in society, and in general, glosses over the many differences between women that matter" (Lippmann, 1999, p. 281, Dubrwiny, 2013 makes a similar assertion). For example, a recent immigrant to the U.S. who speaks no English and has an elementary school education will not be able to make the same sort of informed decision about health as an educated and financially secure middle-class woman.

Even if women did have the same opportunities to make decisions about health, as Dodds (2000) points out, many other factors may come into play in the decision-making process: "For many people, health-care decisions are made in a state of confusion, and the chooser is influenced by a number of internal and external pressures, including pain, discomfort, worry, and concern for others" (Dodds, 2000, p. 217). Furthermore, choice may function to place the burden of responsibility on the person making decisions. Therefore, if a woman makes the wrong choice, it may induce guilt:

> Choice is surely, within lifestyle culture, a modality of constraint. The individual is compelled to be the kind of subject who can make the right choices. By these means new lines and demarcations are drawn between those subjects who are

> judged responsive to the regime of personal responsibility, and those who fail miserably. (McRobbie, 1999, p. 19)

In McRobbie's example, even those women who are better able to make educated decisions could make the "wrong choice," thus leading to feelings of failure. This is an important point because as I will argue in the coming chapters, when competing knowledge claims about the same health risks circulate in the media and medical journals, making choices about health is difficult.

However choice is complicated; as Lippmann (1999) points out, we cannot do away with the concept of choice, especially in regard to women's health decisions. Yet the way in which it is deployed in the current healthcare context is not liberating: "Choice remains a fundamental necessity: it is both a basic civil right and a fundamental social right for all women. It does not reduce to having a menu of biomedical options for treating or preventing disease or for detecting susceptibilities, nor to a list of actions individuals could take to avoid so-far hidden diseases" (p. 287). Therefore, according to Lippmann's assertion, the emphasis on preventive health and the activities women may participate in to possibly prevent illness (including CAM practices and conventional screening techniques) is not inherently good for women's health: it simply demands that women participate in one more seemingly necessary activity.

Taking into account the assertions made by Dubriwny (2013), Gill (2007), McRobbie (2005) and Lippmann (1999), I agree that class and culture are erased in health discourse as important factors in the ability to make choices in healthcare and that

decision-making in that context is never truly autonomous. Further, I argue that even when one does have relatively substantial resources at their disposal, the conflicting information on health risks in reflexive modernity makes decision making difficult. However, reflexivity provides one escape from this paradox. In the following section, I elaborate my theoretical commitment to reflexivity and discuss how it may provide a release from the oppressive aspects of risk and choice as they are discussed within the context of a neoliberal society.

Theoretical Commitment: Reflexivity

As should be clear by now, reflexivity is a word with multiple meanings among the scholars I have cited; it is used conceptually as both framework and tool. I use reflexivity purposely because it has been used by scholars to discuss late modernity (Beck 1992, Dutta & de Souza, 2008)—as opposed to postmodernity[xxii]—and it provides a theory that makes agency and ethics central, something that in my experience has not been sufficiently elaborated by postmodern theorists.

However, as a scholar who has been influenced by Foucault, I briefly sketch how Foucault's ideas can contribute to my project: in particular I will be using his concepts of discipline (specifically achieved through the self-examination) and biopower. I realize that some of the phenomena I analyze in my dissertation may be described using Foucauldian language and theoretical concepts. When this is appropriate, I use his theory to help explicate my point, and illustrate where his work makes a contribution to my own. However, I maintain that it is important to use the concepts he provides to go beyond

destabilization and critique, in order to propose how women's health may be improved. Indeed, Sawicki (1991) and many other feminist scholars—have pointed out that Foucault himself was ambivalent about identifying his contribution to critical theory. She suggests, like many other feminist scholars, that his work is best used as a theoretical tool for critique rather than as a wholesale vision.

For example, as Bartky (1988) argues, Foucault's ability to identify how docile bodies are produced by institutions is an important theoretical contribution, but because he fails to differentiate the stark contrast in how female and male bodies have been subject to docility, it is important to examine the difference in how docility produces a specific form of feminine disciplinarity that is rooted in restriction and self-denial. For example, in *Discipline and Punish*, Foucault aptly notes about exercise, "Exercise, having become an element in the political technology of the body and of duration, does not culminate in a beyond, but tends towards a subjection that has never reached its limit" (1977, p. 162). Yet, as Bartky points out, exercise as a technology shapes female bodies to a difficult-to-attain level of slimness (a figure that she argues defies a majority of adult women's bodies), which is different from how it is used to produce male bodies (to produce bulk and strength). Bartky concedes that muscularity in women has also become fashionable, but observes the social norm maintaining that women remain smaller and less powerful than their male counterparts remains largely intact. Both Foucault's and Bartky's observations on the way that power works through a discourse that emphasizes discipline in diet and exercise practices will be important in my discussion of the connection between beauty and health that I analyze in chapter three.

Foucault's theory also has a contribution to make in this project in his theorization of power as not just repressive, but productive. Power produces bodies—in my study, women's bodies—through social and medical standards that establish a norm for a healthy female body, which leads to self-surveillance and ultimately, helps to produce certain behaviors such as exercise and diet habits that assist women in conforming to this norm. However, I also understand power as productive in the sense that the production of a normalized, fit, youthful body may, in some cases, be experienced by women as positive; for example, in the social rewards and the feelings of personal accomplishment or physical well-being these women may experience that cannot be simply written off as repressive (Heyes, 2007 discusses this in the context of Weight Watchers and Rose 2007, discusses this in the context of genetic counseling).

These disciplinary practices contribute to Foucault's concept of biopower because the individual decisions people make about their health then have consequences for public health and contribute to state initiatives that have an interest in maintaining and promoting the health of the population (such as programs designed to curb obesity). Initiatives such as these are targeted to the public through health campaigns (Gastaldo, 1997). This combination of individual self-monitoring and state interest in the welfare of populations is termed "biopower" by Foucault (see Foucault 1976, Nadesan, 2008). Biopower is a useful means to theorize how individuals and the state conceive health and healthcare management and is also important for analyzing state initiatives designed to promote the health of the population.

Foucault's discussion of biopower is also important to my analysis because a biopolitical imperative is clearly a part of the discourse on the obesity epidemic. Public health initiatives that have specifically targeted the impact of obesity on the U.S. population are closely connected with arguments about the fitness of the nation, which makes the topic of weight an issue of medical importance deserving of attention in popular health media. Thus, in my dissertation, biopolitical imperatives contribute to the construction of normality that legitimates the surveillance of appearance and weight through the self-examination.

Although Foucault scholars have much to offer the field of critical-cultural health communication, especially in terms of thinking about power in terms of the micro-practices of individuals pursuing health maintenance or when considering the state rationalities of public health initiatives in terms of biopower, I believe that Dutta and de Souza's (2008) astute observation that health campaigns still operate within a logic of modernity that reflects very clear differentials in power—especially in regard to health campaigns created by governments and directed towards minority cultures (i.e. a top down construction of power rather than a dispersed form of power)—is the most useful for my rhetorical goal: to point out not only how risk discourses are either restrictive or taken up in ways that are pleasurable, but in how improvement in women's health can be accomplished working within the existing social structure. As I mentioned earlier, Foucault, too, was a critic who used his writings to destabilize social power relations, but his failure to move beyond critique to praxis, makes a wholesale adoption of his framework insufficient for the goals of my project.

Like Beck (1992), Dutta and de Souza (2008) rely on a thesis of reflexive modernity, which they argue is a useful framework for theorizing critical/cultural health communication, "the critical self-confrontation inherent in a modernist enterprise, [which] captures the dialectical tensions between the modern and postmodern elements of contemporary theorizing" (p. 328). In asserting the importance of reflexivity as a guiding framework for critical/cultural studies in health communication they argue that, the "concept of reflexivity allows a discursive space for conceptualizing tensions between the dominant and critical-cultural strands of development communication, and simultaneously explores spaces of collaboration between these tensions in campaign research" (p. 328). Although Dutta and de Souza focus on health campaigns, their commitment to using the concept of reflexive modernity as a means to foreground the dialectical relationship between critical/cultural and dominant approaches to campaign development is useful for analyzing health communication in general, especially in relation to conventional and alternative approaches to health and healing, which have been historically divided by a clear power differential.

Using reflexivity to analyze health campaigns may also help uncover how modernity (in terms of top-down power relationships) still applies to how subaltern groups experience health education programs. "In recent years, critical-cultural scholars have engaged with this notion of reflexive modernity in response to the need for critique in the face of postmodern loss of metanarratives to ground these critiques" (p. 329). What Dutta and de Souza illuminate here is that although postmodern theorizing allows for conceptualizing power in ways that are more complex than the top-down configuration,

the fact remains that many people in the world still experience inequalities in health in a way that reflects a top-down power dynamic. For example, according to the Centers for Disease Control and Prevention (CDC), blacks and Hispanics have significantly higher obesity rates than whites in the U.S., and are therefore targeted for surveillance in ways that whites are not (CDC, 2010). Similarly, because knowledge constitutes reality in the risk society, it remains a given that people will have different access to health care options and choices in relation to their knowledge about health. This clear power differential, which often falls along educational and class lines, illustrates the urgency of retaining reflexive modernity as a guiding framework for theorizing health discourses.

Maintaining self-reflexivity in this project is also key to my political commitments. I acknowledge that I am writing from a position of relative power within an academic community; therefore, it is imperative that my own assertions be open to critical scrutiny. In this spirit, I will try to continue to trouble the assumptions made in the discourses I analyze. However, I also hope to offer a vision of resistance, as the goal for critical scholarship in health communication is the improvement of health, not just criticism for its own sake (Dubriwny, 2013, Dutta & de Souza, 2008).

Methodology

The methodology for this dissertation is Critical Discourse Analysis (CDA). Because I am dealing with texts, both in medical journals and the media, this method helps me to uncover how power and ideology function in the social construction of risk. Discourse

analysis is an important method for studying how health messages are communicated because it uncovers ideologies, a factor not often taken into account as an influence in people's health behaviors by public health officials (Lupton, 1992). However, as I have established throughout this chapter, the social construction of health risks by the media affect how people view, and act on, health. Therefore, illuminating the ideologies in these discourses is important to women's health.

The purpose of CDA is to interrogate how language connects with other elements of social life and functions in power relations, specifically how it figures in unequal power relations (Fairclough, 2001, p. 25). Similarly, my project analyzes how power functions in the discourses of the texts that I analyze. Fairclough (2001) also defines discourse as not just language, but as an element of social relations that is dialectically connected to other social spheres (p. 26). My project also sees language as a significant factor in shaping accepted methodologies within allopathic medicine and what is constructed as important for, and indicative of, women's health by media producers. In addition, Fairclough (2001) points out that CDA does not begin with texts; rather, it begins with social issues (he argues that CDA should be used to analyze how those issues are constructed within language). Similarly, I explore how CAM's entrée into conventional medicine is a contemporary health issue and then analyze how ideology functions in the discursive construction of CAM within the texts I analyze.

Finally, Fairclough's (2001) method aligns with my commitment to reflexivity because he asserts that the purpose of CDA is not just to be critical of how language

functions in social life, but to try to envision a more positive type of semiosis used as one tool in social struggle (p. 26). In addition, as a critical health communication scholar, it is important to not only criticize how health is discursively constructed or which type of healing system is dominant, but to interrogate how constructions of health and socially sanctioned forms of healing function to oppress women in order to illustrate that there is the potential to discursively construct health in different ways.

Statement of Purpose

My dissertation deals with two sites. First, I analyze U.S. medical journal opinion pieces to interrogate how experts construct knowledge about CAM for other professionals. Second, I analyze women's popular health media in order to interrogate how they discursively construct CAM. I analyze both sites with an eye to how risk and reflexivity function discursively through these sites.

Guiding Questions

In this project, I consider the following guiding questions: 1) How is CAM discursively constructed in both medical journals and women's popular media using risk discourses as a justification to use (or not use) CAM? 2) How is CAM articulated to the politics of science both in the medical literature and in popular women's health media, and how is CAM articulated to the politics of science by both professional stakeholders in the medical journals as well as in the popular press? 3) Does the framework of risk and the necessity of choice presented in women's popular health media mask patriarchal values underlying CAM's constitution in women's popular media? 5) How can conventional

ways of understanding medical knowledge (such as the randomized controlled trial) and the individualization bias be challenged in reflexive modernity? During the course of my analysis I found that the concept of risk, which plays a large role in popular women's health media discourses on health and CAM, necessitates "choice"—a politically charged concept that positions women differentially according to their level of knowledge. When risk and choice are used as key constructs in the discursive construction of health by women's popular health media and the medical community, making meaningfully contextual choices about health is difficult, even for educated women, due to the multiplicity of competing knowledge claims. Yet, reflexive modernity also allows for the formation of new ways of envisioning and describing health and this is reflected in the way popular women's health media cover the placebo effect and gender discrimination in the healthcare encounter.

Chapter Outlines

In chapter two I argue that CAM, although seen as a threat to conventional expertise in some of the editorials in medical journals, is also gaining more popularity within conventional medicine, and is thus becoming increasingly mainstream. However, even within the medical community that supports CAM, the potential health risks to uneducated patients who use CAM inappropriately is policed in such a way that it allows little leeway for significantly challenging modernist assumptions and methodologies that inform medical research. Because I am interested in what the application of CAM means for this moment in women's health, I also interrogate the politics of science that have

been used to discursively construct the debate about CAM in the medical journals I analyze. I found that CAM is constituted in the medical journals and women's popular health media as politically significant as well as politically divisive. I found that CAM is becoming a driving force in conventional medicine and that women, because they are the primary consumers of CAM, are being targeted by the media and the journals as a group in need of guidance on how to make the right choices on CAM in order to minimize the risk they will choose sham therapies by differentiating which work and which do not. However, the basis on which this determination is made often relies on scientific methodologies, which reinforce objectivity and which, according to critics of applying these standards universally, are not amenable to testing CAM therapies.

Chapter three details how CAM is articulated to patriarchal beauty standards in women's popular health media, for example by emphasizing beauty and slimness as key indicators of health. I argue that women's voiced anxieties over vanity in these media are mediated by risk discourses that emphasize longevity and health—rather than appearance—as an end goal, thus obscuring the emphasis placed on beauty and slimness as an important indicator of health in these media. When these media use risk discourses in this way, it leads to a focus on individual behaviors as a means to lessen the risk of health problems and thus downplays the social and structural causes of disease.

In chapter four, I argue that women's popular health media provide a forum for the reflexive exploration of the limits of medicine and science in ways that are arguably resistant to the dominance of scientific methodologies in medicine articulated above. I

show that there is at least one example in which these media challenge the methodological assumptions made by conventional medicine, thereby challenging how the medical journals circumscribe CAM. Along this trajectory, I argue that women's popular health media are actively involved in the critique of modern medicine, particularly medical doctors. I show that Dr. Oz validates this critique by positioning himself in opposition to other doctors and aligning himself both with women audiences and with CAM. Given his vast influence in the popular media, this association with women and CAM also works to construct and expand his personal brand. I argue that Oz teaches his audience to be reflexive by alerting them to fraudulent products, such as tainted supplements, and letting them in on doctor secrets, such as their apparent belief that women are crazy. Finally, I provide an example of how Oz's revelation that gender oppression is a problem in medical care is productive for women's health. I end the chapter with a look at what women's popular health media might contribute to a feminist health project that engages reflexively with health discourse. At its best, women's popular health media opens up a space for discussion on the limits of scientific medicine and provides institutional critiques that address the discrimination of women in healthcare, thereby allowing the subjective experiences of women a place of privilege.

Chapter Two: The History of CAM and its Discursive Construction in the Medical Community

> In effect, the role of an expert in a 'risk society' is to claim knowledge, expertise and an ability to control that which seems out of control (Gard and Wright, 2001, p. 538).
>
> By managing uncertainty, the expert becomes central to the construction of a sense of control over the risks we live with (Gard and Wright, 2001, p. 538).

Increasingly, health consumers are turning to CAM as a replacement for, but more often as a supplement to, conventional care. According to the National Center for Complementary and Alternative Medicine (NCCAM), Americans spend $22 billion each year on, "classes, self-help relaxation guides and herbal supplements" (Mohr, 2012, Paragraph 1). CAM has become prevalent in the United States, with frequent estimates citing around 40% of the adult population having used some form of CAM (Cohen, 2012). The use of CAM has also increased substantially in conjunction with conventional care options over the last few years[xxiii]. In a study conducted by the American Hospital Association, 42% of 714 hospitals surveyed offered a CAM therapy in 2010, compared with 27% in 2005 (Fallis, 2012).

CAM use is particularly prevalent among women; according to the NCCAM, (citing findings from a comprehensive survey conducted by the National Institutes of Health [NIH] on the use of CAM in the United States) 48.9% of women versus 37.8% of men have used some CAM therapy. The study also found that women tend to be more health conscious than men as well as serve as "domestic health care managers" in their

families more often than men, thus affecting the overall use of CAM (NCCAM, 2005). This is consistent with historical associations between women, the home, and the management of health for their families (Craddock, 2001). In addition, as Doel and Segrott (2003) note in their analysis of the construction of CAM in British lifestyle magazines, women are assumed by media producers (in their case major magazine editors) to be more interested in health than men. Health consumers who use CAM come from a variety of backgrounds, ages, races, and genders; however, women tend to use and pursue these therapies more often than men (NCCAM, 2008). Research has also shown that women spend about 70% more time on healthcare activities than do men (Krueger, 2009). In addition, women seek preventive care earlier than men, thus making them the main consumers of healthcare in general, and CAM therapies in particular (Pear, 2012).

In this chapter, I argue that the ongoing debate in the medical community about the efficacy of CAM—as evidenced in the journals I examine: *The New England Journal of Medicine (NEJM), The Journal of the American Medical Association (JAMA), Science, and Nature*—relies heavily on the concept of risk (that is, risks to the public for using these therapies), and that this risk is discursively mediated by advancing the randomized controlled trial (RCT) as the only parameter by which to judge therapeutic value. By foregrounding the importance of the RCT, medical and scientific journals use risk discursively to reinforce their own institutional boundaries, as the RCT is the gold standard used to test therapeutic value in medical science. In addition, by ignoring the context in which CAM therapies are used, the journals also reinforce rationalist objectivist assumptions about the body as a biological organism isolated from mental,

social, and structural influences on health. The assumption that the RCT is the only methodology by which to judge efficacy therefore erases gender, race, and class as structural factors that create and sustain health inequities, despite a great deal of evidence that these factors play large and important roles in health. I also argue that because women use CAM more frequently than men, editorials in medical journals that discuss the users of CAM implicitly reference a female audience, thus situating women as subordinate to the medical profession and gendering both CAM issues and medicine. At the end of the chapter, I analyze how the incorporation of CAM into conventional medicine[xxiv] is seen as a politically significant issue in the medical community and the broader public. Using Beck's (1992) theorization of reflexivity and Fairclough's (1999) critical discourse analysis (CDA), I analyze how discourses in the medical journals I examine function ideologically in the maintenance of professional norms. Before I analyze the journals, in the following section I briefly outline the contemporary construction of CAM in the medical community.

CAM in the Medical Community

The efficacy and safety of CAM is contested in the medical community. Although most physicians encourage the use of techniques such as massage for relaxation or eating healthful foods and exercising as a means to maintain or improve health, many doctors argue that treatments such as acupuncture provide no superior pain relief over conventional medications, that supplementation can be useless or even harmful, and that CAM therapies are not able to withstand the rigors of a randomized controlled trial

(Sampson, 2005). While proponents of CAM (including some physicians who support it) argue that these therapies are not amenable to being tested using Western standards (Chan, 2008), debate continues about whether some CAM therapies are useless, dangerous, or should be studied for efficacy at all[xxv].

However, there is a growing movement among many physicians to endorse CAM as a valid supplement to conventional medicine. For example, according to Fallis (2012), writing in the *Canadian Medical Association Journal* (CMAJ), American health care workers personally use CAM more than the general population (83% compared to 63%). This approach is termed integrative medicine[xxvi], which seems to be the term preferred by medical professionals when discussing CAM in a positive light because it indicates that alternative therapies are being used in addition to, rather than instead of, conventional medicine. The increasing influence of integrative medicine in conventional healthcare is exemplified by the growing number of centers for integrative medicine in medical schools across the country, including such prestigious institutions as the medical schools at Columbia University and the Mayo Clinic. According to medical historian James Whorton (2002), more than half of medical schools in the country now have courses in "unconventional medicine." Johnston argues that CAM's acceptance by conventional doctors may, for the first time in American history, mark an era of "medical pluralism" (p. 24). Johnston (2004) also suggests that the current interest in CAM allows for the greatest diversity in healthcare options since "the establishment of modern medical authority in the early 1900s" (Johnston, 2004, p. 1). Yet critics argue that the increasing integration of CAM into the hospital system is a reflection of the market driven model of

healthcare that characterizes American medicine, and that patient demand for CAM services should not outweigh evidence of efficacy (Fallis, 2012).

CAM in American Medical Journals

In order to illustrate the evolving debate about CAM in the medical community, I examine every single opinion piece that discusses CAM substantively from *The New England Journal of Medicine (NEJM), Science, Nature,* and *JAMA* between the years 1983 and 2013, in order to provide a broad perspective on how CAM is viewed in the medical and scientific communities. I chose *NEJM, Science,* and *Nature* because they are the three highest impact biomedical journals[xxvii] and sometimes feature the same authors, arguing with each other across these publications about whether CAM therapies should be incorporated into conventional medicine. Although varying sources rank high impact medical journals differently (Bloom, Sambunjak & Sondorp 2007), I chose to use Eugene Garfield's list of the highest impact *biomedical* journals for two reasons: 1) his piece on high impact biomedical journals was published in *JAMA* (the other journal I am analyzing), and 2) the journals he selected include both medical journals and scientific journals, thus offering a broader view of how the wider scientific community views CAM. I also analyze editorials in *The Journal of the American Medical Association (JAMA).* I selected *JAMA* because according to their website, it is the most widely circulated medical journal in the world, thus offering a perspective from a journal accessible to many practicing physicians.

When I searched "complementary and alternative medicine"[xxviii] in *NEJM*, there were 163 items returned, with 30 labeled as opinion pieces (the rest were study results, letters to the editor or book reviews). Out of the 30 opinion pieces, only nine[xxix] dealt with CAM as the main topic, rather than just referencing it in passing. *Nature* had six opinion pieces on CAM, out of 146 articles that were labeled as opinion, not including letters to the editor or book reviews. *Science* had nine opinion pieces—out of 73—that dealt with CAM. Two of these were letters to the editor, which I included because they were responses to anti-CAM articles published in the journal. Finally, *JAMA* yielded the most results: out of 147 results total, there were 25 that dealt with CAM from an opinion perspective[xxx]. Thus, the set of materials I analyze in this chapter consists of 50 articles. Those that I excerpt in this chapter are representative of the opinions expressed across the journals.

The dates these articles were published are salient. The first article that deals with CAM in *NEJM* was in 1983, and then none appears until 1992, one year after the creation of the Office of Alternative Medicine (OAM). The dates in *Nature* also show the escalating importance of CAM over time: the first article I found was published in 1990, with the remaining six articles all published after that year. *Science* and *JAMA* did not start publishing opinion pieces on CAM until significantly later. The first piece published on CAM in both of those journals was in 1998, the same year the OAM was elevated into a National Institute of Health (NIH) branch—the National Center for Complementary and Alternative Medicine (NCCAM)—illustrating that the creation of the OAM and the NCCAM were crucial moments for the movement of CAM into conventional medicine.

Finally, there was a significant linguistic shift in the journals, from referring to alternative medicine as "quackery" to defining it as CAM or integrative medicine. This shift appears to have happened in the early 1980s. The last time "quackery" was the term used in opinion pieces in *NEJM* and *Nature* was in 1983, in *JAMA* it was a bit later, in 1988, and in *Science* it was earlier still: 1965. My research does not reveal that the early 1980s was a turning point for CAM; however, one article authored in *Science* links the loss of prestige of conventional doctors with the counter-cultural movements of the 1960s and '70s. In the article, Burnham (1982) argues that proponents of those movements challenged doctors' authority, in some cases accusing them of overmedicating patients with little concern for patient harm. The timing of this article, published in a reputable journal, may help indicate when doctors began seriously taking into account public critiques of conventional medicine and also may help illuminate why definitional shifts of alternative medicine might have occurred in the 1980s. The late 1980s is also when the term "alternative medicine" became part of popular lay usage, according to the White House Commission on CAM Policy. It appears that the linguistic shift from quackery to CAM preceded the creation of the OAM, and occurred simultaneously with a crisis of professionalization for doctors of conventional medicine. Each of the journals I analyzed contained coverage that was positive, negative or mixed[xxxi] on CAM; however *Science* and *NEJM* had the highest percentage of negative coverage at 66% and 55% respectively, compared with an equal balance of positive and negative articles in *Nature*, and with 48% of the articles in *JAMA* having mixed coverage[xxxii].

In order to contextualize these articles within the broader framework of the events that have precipitated the emergence of CAM as a viable topic of discussion within the medical community, I use Fairclough's (1999) definition of CDA, a method that analyzes how discourses both shape and are shaped by reality. This is an appropriate methodology for this project, given that the discursive shift from quackery to CAM appears to have preceded the creation of government funded institutes on alternative medicine. Fairclough's approach also fits nicely within the context of Beck's (1992) and Giddens' (1999) argument that late modernity is characterized by the frequent discursive use of risk; they argue that this discourse works to inform individuals' and institutions' views of and responses to modern life.

In addition, Fairclough uses late modernity as a framework and engages with Giddens specifically. He references reflexivity (in the same way that I am using Beck's concept of reflexivity throughout this dissertation) and points out that CDA provides the methodology for analyzing the increasing importance of discourse in late modernity:

> These theories [Giddens' among them] create a space for critical analysis of discourse as a fundamental element in the critical theorization and analysis of late modernity, but since they are not specifically oriented to language they do not properly fit that space. This is where CDA has a contribution to make (1999, p. 4).

Likewise, my project is attending to language in order to analyze how risk discourses function in the medical literature for audiences who are mainly medical and scientific

professionals. How the medical and scientific communities make sense of CAM, and how that is connected with institutional power, is also a question that CDA can help to answer. "CDA assumes that power relations are discursive. In other words, power is transmitted and practiced through discourse" (Fairclough & Chouliaraki, 1999, p. 4). The discursive turn in the medical community from using "quackery" to using "alternative medicine," indicates the influence of the lay population's skepticism of institutional power and illustrates the power of this skepticism to shape institutional agendas in reflexive modernity. Yet, as I will argue later in the chapter, the institutional boundaries of conventional medicine (even among those doctors who support CAM) are still protected by discourses that emphasize scientific objectivity. Thus, the rationalist objectivist framework of biomedicine still strongly informs the profession. Before I discuss the journal articles in depth, I briefly outline the history of CAM in the United States to provide a context for the contemporary discursive construction of CAM.

History

CAM first became popular in Western cultures in the 1700s when the dangers of conventional medical treatments (such as leeching and raising blisters) led people to seek alternative healing that often had fewer or no side effects (Whorton, 2002, p. 6). The invasive and sometimes dangerous practices of the time were termed "heroic medicine" by doctors, because rather than letting nature take its course, doctors were active agents in the patient's "recovery" process. Whorton (2002) notes that for many years conventional doctors had subscribed to one of the important principles of Hippocratic

medicine—that the body is capable of self-healing—but with the advent of heroic medicine, this ideal was lost. “The self-reparative powers of the body had ever since been held in high regard by physicians, though by 1800 that regard had become largely theoretical. Practitioners’ true enthusiasm was for the heroic interventions that took the work of cure out of nature’s hands and placed it in physicians’” (Whorton, 2002, p. 6). Similarly, in contemporary times, the public’s concern over the possible harmful side effects of contemporary Western treatments such as prescription medications also form part of the picture of why consumers choose to use CAM therapies prior to, or in addition to, using Western medicine (Reinberg, 2013).

According to Wharton (2002) the 19th century marked a time of great interest and growth in CAM therapies, including the introduction of chiropractic therapies, hydrotherapy, and homeopathy in the United States. The mind-body connection—a philosophy that informs CAM—also experienced a resurgence during this period with the invention of Christian Science by Mary Baker Eddy in the 1870s and the rise of Mesmerism in the late 1700s. This period was also particularly important in the development and standardization of conventional medical care in the United States. As Whorton notes, this time was marked by debates over the legitimacy of CAM manifest in the conflict between conventional practitioners and so-called “irregulars.”

In addition to being historically positioned in opposition to conventional medicine, CAM in the United States has also historically been connected with women. According to Dror (2004), alternative health practices have long been coded feminine. In

his discussion of how the concept of emotion helped to structure the difference between alternative and conventional medicine in the 1930s, Dror argues that alternative health practices that were more gentle and noninvasive were set up against the more masculine and active "heroic" medicine of the time (2004, p. 73). "These associations between emotion, women, the feminine, and oppositional knowledge ultimately congealed in the particular late-nineteenth-century political constellation that grouped alternative medicine together with the animal protection and anti-vivisection movements, the anti-vaccinationists, and women" (Dror, 2004, p. 73).

Women were not only rhetorically associated with CAM, they also had a long history of actively participating in the CAM movement in the United States. As Ehrenreich and English (2005) and Bix (2004) explain, colonial women were healers in their communities before the establishment of conventional medicine, but were pushed out of their role as healers once the professionalization of medicine took root in America in the 1800s. Ultimately, the professionalization process worked to prevent women from practicing medicine while simultaneously aligning them with "irregulars" and the Thompsonian movement (which sought to retain herbal remedies and traditional healing knowledge that was developed in opposition to the dangerous practices of regular doctors in the United States).

Meanwhile, conventional doctors were trying to standardize and professionalize American medicine; they hoped to model American medicine on what had evolved in Europe: a class-based, gentlemanly profession, open only to elite men who could afford a

medical education (Ehrenreich & English, 2005). Yet, professionalization of regular doctors was not an easy feat: they faced staunch competition from the Popular Health Movement, which was aligned with the feminist movement of the time and also espoused alternative healing practices (Ehrenreich & English, 2005). Another roadblock to be overcome on the path to professionalization was that posed by middle and upper-class consumers who were often the patrons of alternative medicine, such as homeopathy; without the patronage of those patients, regular medicine would not have been able to succeed. Ultimately, however, with the rise of the popular belief in biological science—what Ehrenreich and English (2005) term a "secularized religion"—along with funding for an institute for medical research designed to explore scientific medicine paid by the Rockefellers, scientific medicine gained the authority and funding to become the dominant and widespread accepted form of healing in the United States.

Despite the dominance of men in practicing conventional medicine, women remained active in practicing and at times administering alternative treatments after the professionalization of American medicine. In her essay on the survival of homeopathy during the prominence of the American medical establishment (from 1930-1970), Anne Taylor Kirschmann (2004) points out that the history of homeopathy and the history of feminism as a political project were quite compatible. She argues that women who were excluded from mainstream medicine were able to remain active practicing homeopathy, and notes that prominent first-wave feminists such as Susan B. Anthony and Elizabeth Cady Stanton had homeopathic doctors (Kirschman, 2004). Bix (2004) notes that not only were the majority of homeopathic patients in the 1800s women, The American

Institute of Homeopathy allowed women as members in 1869—46 years before the American Medical Association did. The extension between feminist health activism and homeopathy is still valid. In her interview with female homeopathic practitioners in Britain, Scott (2001) found that many of them identified as feminist and also believed that homeopathic treatments, with their roots in subjectivity (of the patient's experience) and holism (emphasizing the mind-body connection), could be a springboard for effecting larger progressive social changes for women's health because they fully attend to structural causes of disease (such as social oppression).

Although conventional medicine remained the dominant healing system in the United States until the middle of the twentieth century, by the late 1960s alternative medicine experienced a resurgence as a result of the concomitant cultural movements of the time (Kirschmann, 2004). "The embrace of homeopathy by the counterculture of the sixties and seventies reflected a desire to revitalize, purify, and unify the individual body as well as the body politic" (Kirschmann, 2004, p. 35). Alternative medicine was also closely aligned with the women's health movement of the 1960s and '70s, which challenged the male dominated medical field and the biological essentialism that was imposed on women by conventional male doctors. In response, the women's health movement organized self-help groups designed to challenge the values of mainstream medicine, which tended to value clinical, objective knowledge over patients' subjective experiences of health (Kirschmann, 2004, Scott, 2001, and Lupton, 1994).

Women health activists in the 1960s also preferred alternative medicine to conventional medicine for political and social reasons in addition to medical reasons (Bix, 2004). "Advocates rallied women to stand fast, defending their interest in alternative treatments against scorn and criticism from the male-dominated health care establishment" (Bix, 2004, p. 144). During this time, the creation of the Boston Women's Health Collective and the publication of *Our Bodies, Ourselves,* occurred, the latter being a groundbreaking women's health publication that offered a perspective on women's health that did not view women's bodies as pathological (as much of conventional medicine had done) (Bix, 2004, p. 148). Instead, *Our Bodies, Ourselves* provided frank discussions about women's health, covering topics such as sexual health and menstruation without moralization, shame, or obfuscation (as they had been covered in the past by conventional doctors).

By the 1980s, women's health activists were raising concerns about gender differences not being addressed in, for example, the risks and symptoms of heart disease, because medical education tended to use a male body as a standard (Bix, 2004). Perhaps not coincidentally, just one year before the creation of the OAM in 1991, the NIH established an Office of Research on Women's Health (Bix, 2004). Likewise, Bix (2004) argues that the revised editions of *Our Bodies, Ourselves,* released in the 1980s and '90s emphasized some holistic approaches to health and female experiential knowledge.

Alternative practitioners and alternative healing systems likewise align with feminist health objectives that emphasize patient subjectivity and acknowledge social and cultural influences in the creation or absence of good health (Scott, 2001). Alternative

practitioners' sensitivity to women's subjective experiences may also explain the appeal that some contemporary alternative practitioners—such as Andrew Weil and Christiane Northrup—have for women; Northrup and Weil promote themselves as uniquely able to sympathize with the health concerns of modern women who are pulled between career concerns, care of children and aging parents, and the ensuing stress from those roles that can affect overall health and wellbeing. Bix (2004) argues that when alternative practitioners such as Weil and Northrup emphasize the stresses women face and suggest natural remedies such as meditation and yoga to ease health woes, women are offered a perspective that not only acknowledges life's stressors as having an effect on personal health, but provides simple and straightforward solutions to help manage stress. However, acknowledging stress as a factor in health is not only recognized by alternative medicine practitioners: according to the Mayo Clinic, conventional doctors are beginning to acknowledge the influence of stress on overall health as well (The Mayo Clinic, 2011).

Despite the contentious history of CAM in the United States, it is no longer on the medical margins: an increasing number of Americans use CAM, many medical centers integrate CAM therapies into conventional treatment regimens, and now a large, federally funded institute (NCCAM) is devoted solely to researching CAM therapies. However, a vigorous debate is occurring within the medical and scientific communities about how CAM should be evaluated and incorporated into modern medicine.

Even well-known CAM advocates such as Weil and Northrup are also trained as conventional doctors, and like the doctors in the medical journals I analyze, they

advocate an integrative rather than alternative approach. For his part, Weil maintains that the science behind any treatment's efficacy is important to consider. The section on his website about integrative medicine makes a point of asserting that he is not a blanket proponent of CAM, but a supporter of integrative therapies, which, his site argues, uses the best scientifically validated conventional and alternative approaches to treatment (Lemley, 2013). Northrup's site does not have a special section on CAM, but her profile page on the website notes that she, "is a leading proponent of medicine that acknowledges the unity of mind, body, emotions, and spirit" (N.A., 2013). Both Weil's and Northrup's legitimacy and popularity is due in no small part to their impressive conventional credentials. Northrup received her M.D. from Tufts University Medical School and has held varying clinical academic appointments, and Weil, a Harvard graduate, is a clinical professor of medicine and public health at the University of Arizona. Weil's and Northrup's conventional credentials and their adherence to conventional medicine in addition to CAM shows that proponents of CAM are not necessarily anti-science, as some staunch critics of CAM argue in the editorials I analyze. Indeed, I argue Weil's and Northrup's conventional credentials are what lends them widespread credibility in CAM. In the next section, I analyze medical journals as a means to discover how a reliance on a biomedical model grounded in scientific objectivity still undergirds many physicians' support of CAM.

The Medical Journals: Policing the Boundaries of Medicine

Perhaps because the audiences for the medical journals that I analyze are presumed to be medical and scientific professionals, their editorial content about CAM often references the tensions between authenticity and quackery. The discourse is structured around a paternalistic fear of the risks patients assume when using CAM—a tension mediated by suggesting that CAM therapies tested using the RCT will help differentiate "safe" from "unsafe" treatments. This discourse informs doctors' attitudes towards CAM as well as reflects conventional medicine's historical relationship to CAM. As Fairclough (1993) notes, discourse is a form of action, and is historically and socially situated as well as socially constitutive. Therefore, the paternalism of the discourse in the journals both reflects the historical relationship between doctors and women patients, as well as constructs what counts as the socially acceptable attitude for doctors to have towards patients in the medical encounter.

The authors of the editorials in the medical journals I analyze advance two arguments in their debates. The first is that CAM therapies should not be tested at all because they are not effective, whereas the second argument supports testing CAM therapies, but primarily through the use of the RCT. I argue that CAM's entrée into conventional medicine is characteristic of reflexive modernity as it shows how popular interest in CAM and public criticism of allopathic medical expertise comes to influence and re-shape a dominant institution, in this case medicine.

In his discussion of how reflexivity functions in late modernity to challenge experts, specifically scientists, Beck (1992) notes that the, "consciousness of modernization risks has established itself against the *resistance* of scientific rationality. A broad trail of scientific mistakes, misjudgments and minimizations leads to it. The history of the growing consciousness and social recognition of risks coincides with the history of the *de*mystification of the sciences" (p. 59). For example, many advertised prescription medications have a long list of side effects, whereas most CAM therapies do not. One example of this is a new finding that links statins (cholesterol lowering drugs used to prevent heart disease) to an increased risk of musculoskeletal injuries or diseases (Reinberg, 2013). Conversely, CAM therapies such as yoga and massage, which have no negative side effects, have also been found to alleviate anxiety and lower blood pressure, and thus minimize the risk of heart disease (Bulgarelli, 2013). Whereas, doctors would not suggest replacing statins with yoga, for example, the risks linked to statins might encourage those at moderate to low risk of heart disease to use CAM instead of the drug. However, the fear of patients' risks of using CAM expressed in the medical journals, might, for example, reflect concern that a patient at *high* risk of heart disease would use CAM instead of statins, thus putting them at imminent risk of a heart attack.

Although public criticism of medical science may result in the incorporation of alternative therapies into conventional medicine, the institutional reflexivity of the medical profession allows for the incorporation of alternative therapies while still policing the boundaries of acceptable methodologies. In this case, doctors who author articles in these journals acknowledge the popularity of CAM and re-frame it as

acceptable if it meets institutional norms such as the RCT. Kerr and Cunningham-Burley's (2000) discussion of the new human genetics[xxxiii], shows that those who are invested in the new human genetics, including public health officials, scientists, and medical professionals, limit the social and ethical concerns they consider valid in order to enhance professional status and continue to legitimize the field; I argue that the discourse used in medical and science journals about CAM is similar, in that the focus on RCTs limits the extent to which CAM epistemologies, such as holism, may be incorporated to broaden methodological possibilities. For example, a view of the body as holistic, in which mind, body, and spirit are integral to overall health, is simply not amenable to testing using the RCT. Instead, methodologies that include patient's subjective experiences, such as healing that seems to be a result of the placebo effect, would need to be accommodated. "Setting clear boundaries around which areas are and are not open for social consideration, also allows professionals, associated with the new human genetics, to manage concern without undermining research and practice" (Cunningham-Burley, 2000, p. 295). Similarly, the editorials in the journals limit the scope of discourse to focus on whether CAM should even be tested via RCTs, not whether the process of testing CAM therapies should be scrutinized. The discourse in these journals legitimates conventional practitioners by not seriously questioning their methodology (which is the argument for superiority over CAM); this reinforces institutional norms based on a scientific understanding of medicine. Because CDA is concerned with uncovering how power dynamics are enacted in the discursive realm, such as that constituted by medical and scientific journals, I use it to analyze how CAM is discursively bounded. The main

topics of debate in the science and medical journals I analyze include CAM's movement into medical education and the importance of the RCT in maintaining objectivity.

Medical Education

In the following section, I analyze the opinion pieces in the journals that discuss whether or not CAM therapies should be accepted at all by medicine and science. The opinion that CAM therapies should be kept out of medical education is apparent in the discussion of CAM's movement into medical schools and is taken up in both *Nature* and *Science*. In one *Nature* article, Dr. David Colquhoun (apparently one of the most prominent CAM critics in the U.K.) (Milgrom, 2008), accuses the University of Westminster at London of including courses in CAM as a means to increase revenue for the university only because students are interested in the subject matter. Colquhoun specifically attacks homeopathy, which he claims has changed little since the 19th century. To emphasize his point, Colquhoun compares sample test questions from a 19th century medical exam to a contemporary exam from a CAM course at the University of Westminster, seemingly to illustrate how the introduction of CAM classes in universities signifies that medical knowledge is taking a step backwards. His main claim—that CAM practices are "anti-science"—supports his argument that they have no place in the sciences, but should be taught as "sociological history." "Most Complementary and Alternative Medicine (CAM) is not science because the vast majority of it is not based on empirical evidence. Homeopathy, for example, has barely changed since the beginning of the nineteenth century. It is much more like religion than science. Worse still, many of the doctrines of

CAM, and quite a lot of its practitioners, are openly anti-science" (Colquhoun, 2007, p. 373). By comparing homeopathy to religion, which he suggests is opposed to science, he constructs CAM as unable to contribute any benefit to the medical profession, which, in Western culture is evidence-based. By reinforcing the institutional standard of empirical evidence, Colquhoun effectively positions CAM as a hoax, as *only* worthy of studying within the context of history and culture; he thus reinforces the notion that history and culture have no bearing on scientific evidence itself, as if science were outside of these realms. However, there is no discourse, including that produced by scientists, that exists outside of historical and cultural contexts. According to Ehrenreich and English (2005) Colquhoun's position is not far afield from how regular doctors in the U.S. undermined the validity of alternative practitioners in the late 1800s.

In another commentary criticizing CAM's acceptance in medical education featured in a June 2000 issue of *Science*, author Eliot Marshall criticizes institutions such as Harvard Medical School, Columbia, Georgetown, and Stanford for incorporating integrative medicine into the curriculum. Marshall provides a less than positive introduction to the topic: "Medical schools across the country are gingerly bringing alternative medicine into their hallowed halls--much to the consternation of some faculty members" (Marshall, 2000, Paragraph 4). He then turns to Wallace Sampson, a staunch critic of CAM, who refers to CAM as a "secular religion." Sampson claims that CAM "poses a threat to scientific medicine that's 'more serious than anyone realizes'" (Marshal, 2000, Paragraph 6) and claims that medical faculty have not challenged CAM courses because they are fearful that if they do not support the trend of alternative

medicine, their careers will be compromised. Sampson's assertion is immediately followed by a quote from Arnold Relman, former editor of the *NEJM*, who states that he believes that "It is becoming politically incorrect for the movement's critics to express their skepticism too strongly in public" (Marshal, 2000, Paragraph 6). Critics of CAM thus position themselves as at a political disadvantage by suggesting they are being silenced by a popular majority, reinforcing the idea that CAM is a fad rather than a meaningful system of healing.

The article addresses critics' concerns that CAM is a threat to scientific medicine by detailing the popularity of alternative practitioner Dr. Andrew Weil, even highlighting Weil's history of psychedelic drug use. Marshall also includes quotes from doctors who find Weil's approach to health to be incorrect, possibly resulting in patients delaying diagnosis from allopathic physicians when they may have a serious illness. Thus, the riskiness of CAM in this scenario is proposed as delaying the patient's participation in aggressive technological diagnostic techniques. However, the risks of conventional diagnostic techniques such as the radiation from CT scans that could cause cancer later in life, are never mentioned. In other words, CAM is selectively constructed to emphasize CAM's risks, not those of conventional medicine.

The above example illustrates the fundamentally *ideological* nature of risk construction in this context. While Marshall highlights the riskiness of not seeing a conventional practitioner he makes no reference to the diagnostic risks often involved with participating in conventional medical treatment. As Nelkin (1989) and Douglas

(1982) note, the ideological nature of risk construction illustrates which values are associated with the construction of risk. In this case, the bias falls on the side of technological medicine's ability to reduce risks. Fairclough (1999) also notes that ideologies tend to downplay contradictory perspectives, "Ideologies are constructions of practices from particular perspectives (and in that sense 'one-sided') which 'iron out' contradictions, dilemmas and antagonisms of practices in ways which accord with the interests and projects of domination" (p. 26). In this example, the ideology of scientific medicine is used to frame CAM as the only risk.

Finally, Marshall discusses a conventional doctor who also uses CAM treatments and who was fired for encouraging cancer patients to meditate. The editorial ends with the claim that the doctor in question—Dr. Lewis Mehl-Medrona, a Native American—now has a prestigious post at Beth Israel hospital in New York City. Mehl-Medrona responds to this criticism in a letter to the editor that both emphasizes his commitment to spirituality and religion as a means to help patients, and points out that many conventional doctors believe that religious commitments can assist in patients' healing. Mehl-Medrona claims that indigenous means of healing could be used in addition to conventional methods with beneficial results:

> My message has been that we in conventional medicine can learn much from indigenous healers and healing systems. Some of the most important lessons involve the importance of time with the patient and quality of rapport. The world's traditional medicines (including Native American) all stress the

> importance of all aspects of our lives in creating and healing illness. Traditional healers believe that all aspects of the person must be addressed and that major illnesses may require major changes in many areas of life. These areas include diet, relationships, and even spirituality. Many of us feel that these are important issues for conventional medicine to consider. We believe that this is why, as Marshall puts it, alternative medicine is finding its way into the "bastions of academic medicine. (Mehl-Medrona, 2000, Paragraph 7)

Although Mehl-Medrona's response was published, its placement in the letter to the editor section shows that those who support CAM courses being taught in medical school or university curricula are given voice in less prominent forums than those who oppose the incorporation of CAM into medical school curricula. This is also apparent in another letter to the editor entitled, "In Defense of NCCAM" (Straus & Chesney, 2006), which was published in response to Marcus and Grollman's (2006), "Review for NCCAM is Overdue." Milgrom (2008) points out that responses to articles or retractions printed later in a publication make little impact compared with the initial story: "Just like the sound-bite or the attention-grabbing headline, it is the initial impression that sticks, not the more complex retraction buried in the back pages that appears months later" (Milgrom, 2008, p. 592). The ideological position of CAM critics is thus reinforced through the discursive construction of CAM as anti-science; the placement of the articles in the journals also illustrates that this position is the one given more prominent voice.

Although the above editorials are critical of CAM's incorporation into medical education, one *JAMA* article in my sample seems to be supportive of the new trend for

medical residents to be trained in CAM (Lim & Golub, 2004). The authors of this September 1998 commentary assert that the question is not *if* CAM should be incorporated into medical education, but *how* it should be implemented: "As a profession, physicians will increasingly be expected to responsibly advise patients who use, seek, or demand complementary and alternative therapies. We believe the development of a more consistent educational approach to this provocative area is essential" (Wetzel, Eisenberg, & Kaptchuk 1998, Paragraph 37)[xxxiv].

The biomedical journals and *JAMA*—the more widely circulated journal—offer differing perspectives, illustrating that the question over the legitimacy of CAM within the scientific and medical communities is not settled. However, the increasing existence of medical education programs that include CAM components and the trend toward including CAM therapies in conventional medical settings such as hospitals indicate that CAM is becoming a legitimate part of medical care. The increasing incorporation of CAM into conventional medicine indicates a trend consistent with Beck's reflexive modernity thesis, while at the same time the construction of CAM's risks in the journals reveals an ideology of science that promotes it as objective and culturally and historically neutral. Reflexivity thus functions in contradictory ways in this coverage. In the next section, I illustrate how the RCT functions as an institutional buffer to reinforce professional norms and the expertise of conventional doctors.

Scientific Objectivity and the RCT

The argument that alternative medicine has no scientific merit has long been a reason given by conventional practitioners for their stated opposition to CAM (Wharton, 2002, p. 16), and illustrates how the importance of the RCT has not been displaced by the discursive shift from "quackery" to "alternative medicine." The ideology of objective science in the context of medicine therefore remains in place, even while CAM has experienced some institutional recognition. Milgrom (2008), writing on the fundamentalism of the sciences in *The Journal of Complementary and Alternative Medicine,* acknowledges the strong objections many scientists still have to CAM: "The discourse of evidence-based medicine (EBM) has recently been compared to a 'fascist' structure for its active intolerance of pluralism in health care systems" (Milgrom, 2008, p. 589). He uses the term "fascist" to describe evidence-based medicine that uses the RCT to indicate the inability of scientists to cede any ground in this terrain: that is, the possibility that a treatment could be efficacious without using this method of testing. The dominance of the RCT is illustrated both in the anti-CAM and pro-CAM positions. There are two exceptions to this perspective that I elaborate on at the end of this section; but first I detail the discourse surrounding the use of the RCT in testing CAM and analyze how the conversation never seriously challenges this methodology.

The discussion of the RCT within the scientific community points to what Beck (1992) terms "reflexive scientization": that is, public critiques of science force those within the sciences to respond to, and try to protect the integrity of, the scientific method:

> In this way, the revelation of the risks of previous modernization necessarily stirs up the hornets' nest of competitive relations between the scientific professions, and arouses all the impulses to resistance that a scientific profession will have built up over the generations with all of its powers (including its scientific ones) against "expansionist encroachment" on its own "pet problems" and on its carefully installed "pipeline of research funding. (p. 160)

Beck argues that reflexive scientization leads to science losing some of its monopoly on knowledge production; however, he attests that scientific findings are necessary in the construction of knowledge, and those who try to advance oppositional knowledge to the sciences (such as in alternative medicine), will be dependent on the creation of knowledge through the sciences to prove their point. Because of the dependence on science as a means of providing proof, challenging science's monopoly on knowledge is no easy task. One *JAMA* piece cautious about the incorporation of CAM into conventional medicine illustrates the importance of maintaining the status quo in research methods. The authors, Fontanarosa and Lundberg (1998), discuss the importance of ensuring that all medicine be subjected to rigorous scientific standards:

> Alternative therapies that have been shown to be of no benefit (aside from possible placebo effect) or that cause harm should be abandoned immediately. Physicians, insurance plans, medical centers and hospitals, managed care organizations, and government policymakers should base decisions regarding incorporation of and payment for alternative medicine therapies on evidence-

> based research and objective cost-effectiveness analyses rather than on consumer interest, market demand or competition, well-publicized anecdotal reports, or political pressures from well-organized and influential interest groups. (p. 1619)

This quote illustrates the primacy of evidence-based medicine as well as the political nature of the debate within medicine, which I will discuss further in the last section of this chapter. In addition, the connection between the RCT in testing alternative therapies is very closely aligned with concerns that federal research dollars are being "wasted" on therapies that never show promise. For example, writing in the *NEJM*, Sampson (2005) argues that over a billion dollars have been squandered conducting research on CAM remedies that do not have any history of effectiveness and thus should not be subjected to randomized controlled trials:

> It is time for reassessment. First, there is an answer to the question, "Why are we doing randomized clinical trials of folkway uses of herbs and sectarian remedies?" The answer is that proponents and evaluators have excluded plausibility from the equation. What is needed is knowledge-based medicine, with randomized clinical trials of treatments with histories that indicate some reasonable chance of efficacy. This approach mandates a medicine based on evidence that has passed through the sieve of plausibility and that is consistent with basic sciences, other applied sciences, and history — all molded by wisdom and common sense. (Sampson, 2005, Paragraph 11)

Sampson's use of language in this passage such as "folkway" and "sectarian" illustrates a strong ideological position against the methods and epistemological basis of CAM remedies. The discourse of evidence-based medicine, proved through the RCT, is linked to the wider discourse of the healthcare environment—the insurance industry, for example—that requires treatments to be proved before they are covered. However, even such "proof" is subjective, as those critiquing the results, such as meta-researcher and doctor, John Ioannidis, who has devoted his career to proving that data generated from clinical trials and published in medical journals is biased, charge that up to 90% of the information published in medical journals is flawed (Freedman, 2010). Interestingly, Ioannidis is apparently embraced by the medical community. He has published in medical journals and is a popular guest at their conferences, even as he consistently accuses them of bias, more specifically, of designing studies that will win them career prestige, or secure them research funding: "Researchers headed into their studies wanting certain results—and, lo and behold, they were getting them. We think of the scientific process as being objective, rigorous, and even ruthless in separating out what is true from what we merely wish to be true, but in fact it's easy to manipulate results, even unintentionally or unconsciously" (Freedman, 2010, Paragraph 10).

Yet even as they acknowledge the flawed research being published in medical journals scientists and medical doctors continue to reinforce the scientific method as if it generated incontrovertibly substantive proof. For example, in an interview in *Science*, Josephine Briggs, a nephrologist, and the current head of the NCCAM, notes: "the aim [of the institution] is absolutely no relaxation in the notion of rigorous science. We're

going to try very hard to continue to support only very top-ranked, careful, rigorous science" (*Three q.s*, 2008). In her assertion of the importance of rigorous science to the center, she aligns herself with the institutional affiliation of science. In addition, the context for the interview was set by the interviewer who asks her about taking the position. The interviewer asks, "NCCAM is probably the most controversial institute at NIH. That didn't deter you?" (*Three q.s*, 2008, p. 707). Immediately, the tone suggests that taking the position as the head of the Center also would imperil her professional reputation. Because the organization has been on the defensive due to criticism from the medical profession, the RCT provides a way to secure institutional credibility as well as prevents CAM methodologies from threatening the status quo in medicine. When asked if she uses CAM herself, Briggs is cautious; she says that she practices yoga and that CAM can be used to ease the "symptoms of aging." She goes on to say that there are "small, promising areas," and that *some* CAM therapies have *some* effectiveness. Therefore, even the head of the Center aligns herself primarily with scientific medicine, illustrating that the agenda of the Center conforms with conventional medicine's methodological norms.

In my sample just two articles feature authors who overtly challenge the primacy of the RCT: one was in *JAMA* and the other in *Nature.* In *JAMA*, Chan (2008) points out the challenges of testing alternative therapies using controlled clinical trials because healing may be partially due to either the practitioner-patient relationship (which is hard to manufacture in a trial setting) or the placebo effect (Chan raises questions about the difficulty of falsely simulating acupuncture, for example).

In *Nature,* Xu's (2011) opinion piece on the difficulty of using RCTs to study Traditional Chinese Medicine (TCM), highlights this paradox: "[TCM is difficult to study in RCTs] because TCM concoctions are mixtures of multiple active compounds, and a typical Chinese medicine is intended to hit multiple biological targets" (Paragraph 10). Xu also points out that even when compounds are reproduced and used together, the same results may not occur in the laboratory: for example, the herbs may have been grown in different environments (in a natural setting as opposed to ones that are grown in the laboratory setting). As these authors point out, holistic methods of healing are difficult to reduce to Western-centric methods of testing that yield the same, generalizable results. But neither author diminishes CAM's credibility for these reasons.

As I have shown, the language, placement of CAM editorials (either for or against), and the editorials selected for publication by the journals' editors, are all key factors in understanding the journals' (and by extension, larger medical community's) perspective on CAM. I have shown that most of the biomedical journal coverage in my sample is somewhat skeptical of CAM, but that the perspectives expressed in *JAMA* shows strong professional support for CAM within the United States. Both critics and supporters of CAM discuss the public when they talk about why, how, and if CAM should be used. In the next section, I discuss how this construction of the public, regarded by both sides as in need of guidance and easily misled, is composed mostly of women, and discuss the implications of framing the public in this way.

The Feminine Public

CAM coverage in medical journals refers to an abstract, CAM-using public; this public, as I established in the introduction of the chapter, consists mostly of women. However, the fact that women use CAM more frequently than men is not the only way in which this public is gendered. Given the historical context of women's health in the United States that I outlined earlier, and the relationship between conventional medicine and the oppression of women[xxxv], the discursive construction of this audience is not ideologically neutral but reflects persistent patriarchal values that continue to inform conventional medicine. In addition, as Adam and Van Loon (2000) (citing Beck [1992]), argue, the definition of what is risky and who is at risk necessarily requires interpretation and thus becomes malleable to various political agendas. "Analogous of 'relations of production' Beck points to the importance of risk in terms of 'relations of definition'. The pervasiveness of mediation, the high level of indeterminacy and the inevitability of political involvement mean there is no one truth, that there are no facts outside the relativizing influence of interpretations based on context, position, perspective, interest, and the power to define and colour interpretation" (Adam & Van Loon, 2000, p. 4). In addition, even women scientists acknowledge that the scientific profession does not treat women and men equally; as scientist Jennifer Rohn (2010) notes in *Nature*, "science is still inherently sexist" (Paragraph 1)[xxxvi].

Although the patriarchal tone in the journal articles may not be designed to overtly manipulate or position women as subservient, the history of knowledge that

informs conventional medicine and is rooted in the social oppression of women provides a context for medical culture that is still influenced by that knowledge and identifies the CAM-using public as "at risk." In the following section, I analyze how the editorials in medical journals construct the CAM-using public as gullible and in need of guidance, this discourse also works to contribute to disciplinary solidarity at the same time it creates a straw figure of the public. Although the reference to women is implicit, the journals show a bias against racial and cultural "others" who are included as part of the public discussed in the journals. Therefore, this coverage is not only patriarchal, but includes troubling racial overtones.

Construction of the Public in Medical Journal Editorials

As I outlined in the last section, even the supporters of CAM in the medical journals highlight the importance of the RCT as the means by which CAM therapies should be tested. Along with providing validity for these therapies, the authors of the editorials in the journals argue that CAM therapies must be tested rigorously because the public is gullible and will use the therapies regardless of whether or not they are tested or show results. Such paternalism suggests that only benevolent doctors are capable of shepherding patients in the correct direction. For example, one *NEJM* article *supporting* CAM deems the use of herbal medicines a "public health experiment." "We are in the midst of a public health experiment that much of academic medicine has failed to acknowledge until recently. In spite of the greatest health and longevity in history in the United States and Europe, millions are turning back to traditional herbal medicines in

order to prevent or treat a host of illnesses" (Straus, 2002, Paragraph 1). This quote illustrates that doctors believe science-based medicine has a direct correlation to increased life-span (which it surely has had a hand in); however, discussing this achievement in relation to CAM suggests that CAM is the reason for poor longevity in the past; the phrase "in spite of the greatest" points to an odd, intractable tendency of the public to take supplements regardless of good health. Suggesting that the public uses supplements in opposition to conventional care recommendations—ignores how most Americans use CAM: in addition to, rather than instead of, conventional medicine.

In another example of the construction of a gullible public in the journals, published in December 1998 in *Science*, author Jennifer Couzin explores whether the public is intelligent enough to believe research that questions the efficacy of CAM. "But some critics question whether the public will accept even the most rigorous research if it exposes popular remedies as useless. 'There have been a gazillion studies showing that astrology doesn't predict anything at all, and people still use astrology,' says Ursula Goodenough, a Washington University, St. Louis, biologist and a former president of the American Society of Cell Biology" (Couzin, 1998, Paragraph 3). The public implicitly referenced here, as I mentioned earlier, is composed mostly of women, who also happen to believe in astrology more than men (Lyons, 2005). Given that the author of the article and the biologist she quotes point to the ignorance of the public without explicitly referencing women, the content is not clearly sexist; however, as Fairclough (1993) points out, the relationship between causality and determination is often opaque, which obscures how discourse is connected with wider structural and cultural ideologies and

thus contributes to securing power and hegemony by dominant groups (p. 135). In my example, the article works to secure the dominance of scientific expertise over supposedly flawed lay perceptions. Because the readers of these journals are medical and scientific professionals, these articles function to strengthen affiliation with disciplinary norms. The presence of these types of editorials suggests that the popularity of CAM has become threatening as it encroaches on a field that used to enjoy relative autonomy. The incorporation of CAM into mainstream medicine means a major disciplinary overhaul, including adding classes to medical school curricula and making funding for studies on treatments and getting patient business more competitive. These are only a few of the reasons these antagonisms against CAM play out in professional journals.

The above example also illustrates how women may participate in undermining feminist goals. For example, in her discussion of how feminism can be undermined by female individualization (which I defined in my introductory chapter), McRobbie (2005) points out that women in positions of privilege may overlook the fact that their own opportunities for education are not equally accessible to all women, thus exacerbating social inequalities among women. “As well-trained women gain their own more independent middle-class status so also are they encouraged to repudiate their social inferiors and celebrate their own individualistic success” (p. 72). She specifically alludes to how the imperative for young women to succeed in the workforce and in cultivating a particular appearance (encouraged by both government policies that reward meritocratic educational achievements and cultural institutions, such as the fashion industry), heightens divisiveness between women. “This landscape of self-improvement substitutes

for the feminist values of solidarity and support and instead embraces and promotes female individualization and condemnation of those who remain unable or unwilling to help themselves" (p. 73). In the above example the disdainfulness of Goodenough's quote, illustrates that anyone believing in astrology is foolish and not intelligent enough to understand the scientific process. Because of the clear divide established by the author and scientist in this article and the public—educated, knowledgeable about science versus uneducated and, foolish, the article supports an implicit postfeminist position that supports a stratification of women along ideological lines.

Yet, my example is somewhat different from McRobbie's argument about stratification of the classes. As I pointed out in the first and second chapters, CAM consumers tend to be white, middle-class women who are also educated; thus, rather than being about class stratification, this quote illustrates the ideological divisiveness of the debate that pits women scientists against other professional women. In this case too, then, the institutional boundaries are protected while the larger issue of how to best approach women's health (both from a scientific as well as holistic perspective) is undermined.

Concern over the public's ability to make sound decisions and to discern fact from fiction is also highlighted in an editorial in *JAMA* entitled "Beyond the teachable moment." According to author Dr. Alan Leshner, the public and scientific communities have a tense relationship because the public has little understanding of the scientific method, is reluctant to ask for evidence based medicine, and is concerned about how science is encroaching on personal values and beliefs (Leshner, 2007). To illustrate this

point, he equates parents' supposed reasons for abstaining from vaccinating their children with the Gardasil vaccine with creationism. Leshner raises the possibility that patients seek alternative therapies because they are frustrated with the slow progress of medical science; however, he too, foregrounds the public's ignorance:

> Frequently, people do not know the difference between evidence-based and non–evidence-based treatments. Even as the public is reminded that "the plural of anecdote is not evidence," widespread publicity for the purported effectiveness of nonscientific treatments perpetuates the trend and undermines the call for adherence to the science base. (p. 1326)

Leshner (2007) follows this statement with a claim that alternative medicine may still have a place in conventional care, and reiterates the importance of the RCT by using the NCCAM as an example of a valid institution that is doing reputable, science-based research in order to discern which alternative therapies are helpful and which should be abandoned.

Leshner's piece is not critical of CAM in general, but of the public's apparent blind faith in things that are not science-based. To emphasize his point on public ignorance, Leshner provides statistics about the number of Americans who believe in extrasensory perception, astrology, and who do not believe in evolution, as if these figures provide *prima facie* evidence of their inability to make rational decisions. He then balks at the ignorance of parents (read mothers)[xxxvii] who oppose the Gardasil vaccine,

and groups them together with parents (again, mothers) who are fearful of the link between the MMR vaccine and autism:

> In the medical realm, some US parents, fearful of seeming to endorse premarital sex, resist providing their daughters with the first human cancer vaccine, although the American Academy of Pediatrics describes this vaccine as "highly effective" at preventing 4 types of human papillomavirus infection, the major cause of cervical cancer. Similarly, rumors of a link between the measles-mumps-rubella vaccine and autism remain unsubstantiated, yet public fears persist. (p. 1326)

While Leshner's argument seems straightforward, the implications of Gardasil are not universally endorsed by the American Academy of Pediatrics for all girls, and there are concerns about possible serious side effects, such as seizures or paralysis (Lind, 2013) that are unrelated to concerns over teen promiscuity (or the fear that being vaccinated for an STD will encourage teen girls to have more, and unprotected, sex) (Fernandez Branson, 2012).

Leshner continues to argue that an "antiscientific" attitude is a public problem and compares it to Galileo's conflict with the Roman Catholic Church. He cites the debate surrounding the teaching of creationism or intelligent design alongside evolution in schools as an example: "Members of the general public who know little about the nature and requirements of science have little chance of realizing that there is no science base behind creationism and intelligent design. This complexity reiterates the need for the public to better understand the nature of science" (Leshner 2007, p. 1327). Leshner

concludes the article by saying that science and religion should not be pitted against one another and that biomedical scientists should listen to and learn from the public. However, throughout the article Leshner appears to make an argument for how biomedical scientists need to better influence and be prepared to argue against the ignorant beliefs held by an uneducated public.

Leshner's article illustrates how scientists see themselves as different from the public. He also constructs a straw-figure argument that assumes parents' resistance to the HPV vaccine is testament to their belief in creationism at the same time he ignores the fact that some parents may also be scientists or otherwise capable of doing research on the side effects themselves. In his discussion of the politics of knowledge production in the risk society, Beck points out the divide between experts who believe they possess superior knowledge to that of the lay public:

This division of the world between experts and non-experts also contains an image of the public sphere. The "irrationality" of "deviating" public risk "perception" lies in the fact that, in the eyes of technological elite, the majority of the public still behaves like engineering students in their first semester. They are ignorant, of course, but well intentioned; hard-working, but without a clue. In this view, the population is composed of nothing but would-be engineers, who do not yet possess sufficient knowledge. They only need be stuffed full of technical details, and then they will share the experts' viewpoint and assessment of the technical manageability of risks, and thus their lack of risk. Protests, fears, criticism, or resistance in the public sphere are a pure problem of

information. If the public only knew what the technical people know, they would be put at ease—otherwise they are just hopelessly irrational (1992, p. 58).

Beck (1992) continues by noting that there are no external checks to scientific or medical innovations; the decisions are scrutinized only within the institutional culture of medicine and science. For example, when the risks and benefits of a particular treatment—in-vitro fertilization, for example—are assessed by scientists and medical professionals, they may leave out ethical and social questions that are important to the public, such as the side effects of the treatment, the cost, or the overpopulation of the planet. Because scientists rely only on their internal standards that encourage the progress of knowledge, they fail to adequately address social concerns about the possible social consequences of a new scientific discovery until after the innovation or new technology has become used:

> In this way a complete disequilibrium between external discussions and controls and the internal definition-making power of medical practice comes in being and is preserved. According to scientists, the public sphere and politics are always and necessarily "uninformed," lagging hopelessly behind the developments, and thinking in terms of moral and social consequences that are alien to the thought and action of medical people (p. 208).

Beck's statement is quite broad; however, his assessment of scientists' perceptions of lay people fits well with my analysis of how the public is discursively constructed in the journals I analyze and reflects how scientists tend to feel about outside intervention into

their research agendas, even as they fail to adequately interrogate not only the ethical outcomes of their research but their own research findings:

> University and government research overseers rarely step in to directly enforce research quality, and when they do, the science community goes ballistic over the outside interference. The ultimate protection against research error and bias is supposed to come from the way scientists constantly retest each other's results—except they don't. Only the most prominent findings are likely to be put to the test, because there's likely to be publication payoff in firming up the proof, or contradicting it (Freedman, 2010, page 2, Paragraph 8).

However, as I outline in the next section, many scientists do not feel that they have a monopoly on knowledge production; instead, as the above quote illustrates, they are quite fearful of the encroachment of political policy on independent research.

Along with discussion of the public as easily misled and uninformed, in these journals' discussions of the public as patients, there are also negative racial overtones to their construction of the public who uses CAM. In one such article, a patient-doctor scenario featured a Chinese man who was treating his daughter's asthma with herbal remedies in addition to her inhaler. Although the author does not suggest the herbal remedies did any harm to the girl, he emphasizes the need for doctors to correct such a patient's use of CAM as a means to provide better care:

> Once the herbal treatment was revealed, the appropriate use of inhalers could be reviewed and reemphasized. In such cases, effective communication may require

> interpreters, and clinicians must be trained in their use. Key steps in building trust include acknowledging patients' concerns, orienting them to the doctor's decision-making process, noting that many patients are mistrustful of the health care system, and offering reassurance. (Betancourt, 2004, Paragraph 9)

This quote not only illustrates a CAM therapy articulation to an immigrant group—with a negative association—but also emphasizes patient compliance over considering a CAM treatment as a viable addition to standard Western therapy. The passage is patronizing of the public as the previous examples I illustrated, but also reveals a racialized component at the same time it shows that doctors are aware of patients' suspicion of conventional medicine and thus must manage and re-direct patient expectations to encourage compliance, rather than even hinting at the possibility that the clinician could learn from patients here. A similar example in *JAMA* articulates CAM negatively with non-Anglo cultures:

> Despite shared values and goals, alternative medicine and conventional medicine differ in important ways. First, many alternative medicine modalities are derived from cultures other than the Western one in which conventional medicine was developed, and many of the practitioners subscribe to a different worldview. Second, by definition, alternative medicine represents a different approach to healing. Third, users of alternative medicine tend to perceive these modalities, in comparison to conventional ones, in greater concordance with their views toward health care. Thus, there seems to be distinct cultures of healing, which is

> somewhat analogous to situations that conventional medicine encounters in other cultures. For instance, what constitutes appropriate research in developing countries? Should patients be told about a diagnosis of cancer? Should advance directives be discussed with patients whose culture proscribes these discussions? How should clinicians respond to requests for female circumcision? In each of these cases, just as when clinicians encounter alternative medicine, it is essential to determine an appropriate response. When is a laissez-fare approach acceptable? When is there an obligation to intervene on behalf of patients? (Sugarman & Burk, 1998, p. 1624)

In this excerpt, CAM is presented as a cultural problem that physicians must be prepared to deal with by intervening when necessary. The questions the author raises construct other cultures as fundamentally flawed in their approaches to medicine and medical ethics and by default, as the last question illustrates, assumed to be not necessarily in the patient's best interest.

Although the public is referred to as misguided or easily duped in medical journal coverage, it is almost never explicitly gendered. However, in a 2005 *JAMA* article, Dr. Diana Petitti discusses study results that apparently prove that many menopausal symptoms experienced by women are actually psychological and not physical. Petitti cites a study conducted by the Women's Health Initiative (WHI) that showed over 40% of women experienced moderate to severe menopausal symptoms after they stopped taking a placebo. "This 'placebo withdrawal effect'—combined with the data suggesting

that simple lifestyle changes relieve some symptoms in at least some women—raises questions about the physiological basis of some of the symptoms that have always been associated with the estrogen-deficient state" (Petitti, 2005, p. 245). She cites another study showing little causal effect between ovarian aging and the symptoms of menopause. Petitti concludes the article by suggesting that menopausal symptoms may instead be the result of symptoms of general aging.

While the psychosomatic explanation for menopausal women could be read as problematic, Pettiti's ultimate suggestion—that menopausal symptoms are largely composed of general aging symptoms—challenges the conventional medical perspective that ovarian function is central to the experience of female aging. As Bix (2004, p. 164) also points out, many feminists who challenged the validity of HRT therapy criticized pharmaceutical companies for defining menopause as an illness and were trying to reclaim menopause as a natural process rather than a pathological disease. Ultimately, Pettiti's suggestion that most women should manage menopausal symptoms with simple lifestyle changes achieves the ultimate goal for which some feminists opposed to HRT were pushing.

Regardless of whether the editorials support CAM, the coverage in the three biomedical journals and *JAMA* typically construct the public as gullible and in need of professional guidance. Based on the historical connection between women and CAM and the current popularity of CAM among women, I argue that the discursive construction of a CAM-using public in these editorials references women. Although women are rarely

mentioned in the medical journals, it is through these silences that the continuation of gender oppression in medicine serves to differentiate women and non-Anglo patients as primitive, emotional, or lacking knowledge.

Yet the construction of women as gullible does not completely strip them of their agency. Because women also make up the majority of health consumers, their decisions have economic consequences for the direction of healthcare, and their market power has the ability to partially determine which therapies become sanctioned through insurance coverage. Because of their consumer power, they are thus in a position to potentially re-shape the contours of accepted treatment options.

These journals' construction of a gullible public in need of direction references anxieties around the shifting terrain of healthcare therapies, medical education, and government funds that are contentious issues in the contemporary medical profession. In the next section, I explain how medical journals incorporate CAM into conventional medicine as if it were politically significant and divisive. I argue that while the medical community views the politics of CAM in terms of its ability to withstand the rigors of science, the public crosses traditional political divides between Republican and Democrat in order to organize around a politics that fights to include CAM in mainstream medical care. Thus, the divide between CAM and allopathic medicine is not necessarily between political conservatives and liberals, but between a wide swath of the public and a segment of professionals within medicine and the sciences who believe CAM threatens the reputability of conventional medicine.

The Politics and Sub-Politics of Medicine

In his discussion of the differences between politics and sub-politics, Beck (1992) argues that whereas politics is democratically legitimated and contains checks and balances through the law and other forums, sub-politics—in particular, the sub-politics of medicine—checks itself only against its own internal professional standards, thus excluding other voices from determining what is researched and funded. In the sub-politics of medicine Beck argues, "It is the model of an undifferentiated authority to act, which does not yet know the separation of powers, and in which social goals only need be conceded to the affected parties retrospectively, as secondary consequences that have already become a reality" (p. 209). It is this institutional power that scientists and doctors hope to retain, without the influence of what they perceive as an uneducated public.

As Whorton (2002) notes, the conflict between alternative and conventional medicine has always been a political struggle: "Indeed, the history of alternative medicine is, almost by definition, the story of outsiders fighting the establishment, and, awkward though it sounds, there is considerable merit in another of the names that has been suggested for unconventional practice: counterhegemonic medicine" (p. 23). Whorton's insight about the counterhegemonic nature of alternative medicine is important because it references both the history of conventional medicine's demonization of CAM as well as speaks to those historically associated with CAM—women and institutional outsiders who tried to challenge allopathic medicine's dominance in

healthcare. In order to provide a context for the contemporary debate within the medical community over CAM, in the following section I discuss the history of the NCCAM

History of the NCCAM

The NCCAM was created in 1998, a significant moment in CAM's integration into mainstream medical practice. Wharton (2002) also identifies the creation of the OAM as an important political moment that signified the entrée of alternative medicine into the mainstream and created controversy within the medical community. "The decision by the U.S. Congress in 1991 to establish an Office of Alternative Medicine at the National Institutes of Health was, to be sure, a political act, and one that enraged many MDs" (Whorton, 2002, p. x). The coverage in the medical journals I examined supports Wharton's claim that the establishment of the Office of Alternative Medicine (OAM), and later, the NCCAM, were important developments in the acceptability of CAM (to a certain extent) within the medical community. For example, *JAMA* devoted an entire issue to alternative medicine in 1998 and the majority of the editorials written in that issue were in favor of the formation of the NCCAM[xxxviii]. *Science* included two articles on the development of the NCCAM in 1997 and 1998 respectively. The 1998 article in *Science* was cautiously skeptical. Although both sides of the argument—those who favored the creation of the NCCAM as well as those who questioned the political motivations behind its becoming a Center—were featured, the article concluded with perspectives from scientists who disagreed with the efficacy of alternative therapies and claimed that politics trumped science in the creation of the center:

> Clearly the political push for expanding [the office] into a center didn't want to wait for any critical review," says Nobel prize-winning biologist Paul Berg of the Stanford University School of Medicine. Nevertheless, Berg and Goodenough both say they would support rigorous clinical trials of treatments such as acupuncture, homeopathy, and herbal therapies. As Varmus puts it: "I think there's a lot to learn; there's probably a lot to debunk. (Couzin, 1998, Paragraphs 11 and 12)

Ending the article on such a note offers a skeptical view of the NCCAM, a trend that continued in *Science.* Nearly ten years after the publication of this article, the validity of the NCCAM is still debated in *Science,* after an article authored by Donald M. Marcus of Baylor College of Medicine and Arthur P. Grollman of the Department of Pharmacological Sciences at State University of New York, Stonybrook raised questions about the research standards of the NCCAM. In their article, Marcus and Grollman claim that the research agenda at the NCCAM is shaped by politics rather than science.

Positioning science as *outside* of, and superior to, politics reinforces its supposedly ideologically neutral character and reinforces the modernist discourse of objectivity, neutrality, and progress that are central concepts informing the scientific profession. In addition, as Fairclough (1993) points out, because language is constitutive of both identity and knowledge production, there is no knowledge that exists separate from the discursive realm. Ideology is thus masked behind a guise of neutrality, contributing to the opacity of the links between discourse and society (Fairclough, 1993,

p. 135). In my study, most of the authors in the medical journals deny the social situatedness of science, positioning it as outside of politics and thus obscuring how scientific knowledge is also produced under social circumstances that include the types and agendas of organizations funding the research, what outcomes are hoped for or expected, and the people who are conducting the experiments (Dubriwny, 2013).

In another piece that suggests politics have too much influence on scientific practice, a January 2005 article in *Science* discusses the possibility of Florida State University opening the first chiropractic medical school. Author Bhattacharjee (2005) notes that FSU is planning on opening the school, because an unnamed Florida senator, who is also a chiropractor, urged the Florida legislature to provide $9 million dollars a year to fund the school. The article includes quotes from both sides of the debate, but ends with a firm assertion against opening the school:

> None of those arguments is enough to convince neuroscientist Marc Freeman, one of 40 FSU professors—including Nobel Prize-winning chemist Harry Kroto and physicist J. Robert Schrieffer—who have signed a petition against the proposal. Apart from the lack of a scientific basis, he says, the chiropractic school is a threat to FSU's academic independence. “We cannot have the legislature forcing a program on a public university,” he says. (Bhattacharjee, 2005, p. 194)

A large graphic of a faux university campus map accompanies the article. Illustrated by Albert Stiegman, a chemist at FSU, the map shows an oversized chiropractic medicine building along with neighboring buildings, including “tarot studies,” a “bigfoot institute,” and a “crop circle simulation laboratory” among others. The caption to the map, reads,

"This fictitious map of FSU's main campus, by chemist Albert Stiegman, has helped rally faculty opposition to a chiropractic school" (Bhattacharjee, 2005, p. 194). Ultimately the school did not materialize and so critics of the program, in this case those on the side of traditional science, prevailed.

In a similar vein, the journals I have reviewed also frequently feature critics of the NCCAM who claim that its research is without rigorous scientific standards, and, therefore, is wasteful of taxpayer dollars. In one debate in *Science*, prominent critics discredit its work citing flawed methodology, biased researchers, and questionable uses of funding. For example, the Marcus and Grollman (2006) article that I mentioned earlier is a part of this debate, focusing on their concerns that ten years after the center was formed, many of the CAM therapies that have been tested by the NCCAM have been proven useless. The authors focus on the NCCAM's failure to prove that herbal remedies have efficacy, including Echinacea (as a cold remedy) and St. John's Wort (for depression), both of which have been proven to be ineffective using conventional testing (Marcus & Grollman, 2006). According to a later article published in *Nature*, because the Center has proved these herbal remedies ineffective, the mission of the center is changing to focus on the "mind-body connection" and using CAM therapies for pain management rather than exploring the apparently unfruitful avenue of discovering the healing potential of herbs (Wadman, 2009).

Wadman's (2009) article also features quotes from Steven Novella, a neurologist at Yale University (who also appears on *The Dr. Oz Show* as I will discuss in chapter

four), and Marcus, both of whom are members of the Institute for Science in Medicine: a group of physicians and scientists who fight policies that support alternative medicine. Marcus asserts that the NCCAM has been a waste of money, and suggests that the center be dissolved; however, he acknowledges this probably will not happen because, he claims, Senator Tom Harkin (D-IA), who authored the bill that formed the NCCAM, is 'too powerful'" (Wadman, 2009, Paragraph 12). The article concludes by validating Marcus' sentiments: "A decade after the NCCAM's birth that power remains on display: Harkin and others have inserted provisions in health-reform bills in both houses of Congress mandating that insurers reimburse state-licensed alternative medicine providers" (Wadman, 2009, Paragraph 13). The medical journal coverage in *NEJM*, *Science* and *Nature* suggests that those physicians who support CAM therapies are simply pandering to a consumer market and encouraging patients to believe in something that is not effective. They see the support for CAM as a political issue, one that challenges the legitimacy of the established profession and is framed as a battle that conventional science is losing.

One article in *Nature*[xxxix], however, discusses the public being a possible buffer against the infringement of policy on science: "And although fears of the politicization of science are easily overblown, the time may come—perhaps it is here already—when direct public involvement may be the best protection against politicians who are selectively unfriendly to scientific freedoms" (Taylor, 2007, p. 163). Taylor's article is perhaps most sympathetic to the public, and asks the most of scientists. He demands that scientists respond to the public's concerns over the ethical and social implications of

research, and encourages independent research regardless of funding sources. However, the article's focus is still on persuading the public to understand the scientific community's position and increase scientists' credibility with the public.

Meanwhile, *JAMA's* coverage is much more sympathetic to the possibility that alternative therapies may be effective in some cases; even so, *JAMA* still frames the debate between CAM and conventional medicine as political. "Despite the popularity of alternative medicine, conventional medicine is arguably the *politically* dominant health system with a somewhat circumscribed set of practices that differ from alternative therapies" (Sugarman & Burk, 1998, p. 1623). The *JAMA* editorial highlights therapies that have been both proven and disproven, continuously calling for the need to continue testing alternative treatments:

> The spectrum of possible responses to alternative medicine is quite broad, ranging from an obligation to stifle harmful practices to mere acceptance of nonharmful modalities, to encouraging the use of beneficial interventions. Obviously, none of these singular approaches is adequate or appropriate in all cases. Rather, given the diversity of modalities embraced by a broad definition of alternative medicine and medical uncertainties regarding safety and efficacy, each approach is at times correct. (Sugarman & Burk, 1998, p.1624)

Sugarman and Burk go on to respond to some of the criticism in the other journals about the invalidity of the NCCAM:

> Despite this argument, some skeptical clinicians may still object, claiming that investigating these approaches wastes scarce research dollars and encourages patients to invest their money in sources of false hope. Nevertheless, if this research is conducted properly, the extent to which alternative medicine therapies meet patients' expectations will be clear. Armed with these data, harmful or useless practices could be abandoned and clinicians would be better positioned to help their patients make informed decisions to reach essential health-related goals. (Sugarman & Burk, 1998, p. 1625)

So, while Sugarman and Burk support alternative health research, they also reassert both the primacy of scientific standards and the supremacy of doctors as the ultimate guides for patients.

The introductory editorial in this same issue devoted to alternative medicine, supports the NCCAM:

> The activities of the Office of Alternative Medicine and the publication of this issue of JAMA illustrate that quality scientific research can be conducted and published on alternative medicine topics. It appears that complementary and alternative medicine has again "come of age" in the United States. However, the rush to embrace a new integration of alternative and conventional medicine should be approached with great caution. Alternative medicine, like conventional medicine, has pros and cons, promotes bad ideas and good ones, and promises to hold both benefits and risks. (Jonas, 1998, p. 1616)

Despite this initial support, Sugarman and Burk (1998) and Jonas (1998) make clear that rigorous scientific standards must be upheld, and that alternative medicine must be held to the same standards as conventional medicine:

> To adopt alternative medicine without developing quality standards for its practices, products, and research is to return to a time in medicine when quackery and therapeutic confusion prevailed. Modern conventional medicine excels in the areas of quality health care and the use of science: alternative medicine must change to adopt similar standards (Jonas, 1998, p. 1617).

Although this is a strong statement for maintaining the primacy of scientific methodologies, the article ends by exploring how conventional medicine can learn from alternative medicine, including how doctors may be more gentle in administering treatments, changing the language of healing to be more appealing to patients, and acknowledging the power and possibility of the body to self-heal. Jonas (1998) concludes by claiming alternative medicine should not be marginalized but explored in greater depth in order to retain practices or therapies that may be beneficial to patients.

Contrary to some of the skepticism expressed about politicians in the medical journals, political supporters of the NCCAM, such as Representative John Porter (R-IL), interviewed in a 1998 article in *Science*, also emphasize the need for rigorous science and of the importance of convincing the public of which therapies are beneficial. "'I don't think it would be good to have a stream of negative messages' about the value of such treatments that were not based on sound science, says Porter, who chairs the

subcommittee that handles NIH's budget. To a public that's supportive of such therapies, says Porter, it would ‘seem like a conspiracy [against alternative medicine]’" (Couzin, 1998, Paragraph 3). So, while doctors who support evidence-based medicine based on the RCT suggest that politicians are unable to understand or respect their autonomy this quote indicates that politicians who support the NCCAM also support scientific methodologies and testing of CAM therapies.

The Politics of CAM in the Public Sphere

Although interest in alternative medicine might be considered anti-establishment, as Johnston (2004) points out, it is not mainly a politically liberal or politically conservative issue. In fact, according to Johnston (2004), the legislators with the most impact in expanding the OAM are from both ends of the ideological spectrum: liberal Senator Tom Harkin (D-IA) and conservative Senator Orrin Hatch (R-UT). Sociologist Michael Goldstein argues that alternative medicine serves both liberal and conservative interests because liberals espouse the counter-cultural component of alternative medicine that emphasizes alternative healing, while social conservatives believe in the element of personal responsibility and non-governmental solutions often forwarded by alternative practitioners (Johnston, 2004, p. 4).

Schneirov and Geczik (2004) similarly identify the alternative health movement as a social movement that bridges the divide between the political right and left. They argue that both come together over their distrust of political and medical authority. In their study investigating two groups of people who were interested in CAM—one

identified as politically conservative, working-class Christian and the other identified as politically liberal with an interest in Eastern philosophy—the authors found that both groups shared a common interest in being able to experiment with alternative medical treatments without the interference of government. “For example, both groups oppose governmental regulations of alternative health products and treatments and believe that patients have the right to pursue and even self-administer unconventional treatments that have not been approved by the FDA” (Schneirov & Gecznik, 2004, p. 235). Both groups also emphasize the importance of individual responsibility in health care. As alternative health users, they see themselves as more active and self-educated about their health in contrast to being passive patients of the medical establishment (Schneirov & Gecznik, 2004, p. 236). Similar to how Dubrwiny (2013) describes biosocial communities (or those groups organized by sufferers of a particular disease) in pushing for funding and advocacy for their cause, CAM proponents may be understood as working together in the same way to expand how medical care is practiced in the United States.

In addition, both liberal and conservative groups share a critique of commodification and consumer culture along with a critique of modern medicine’s institutions. While the problematic assumption of individualization—for example, how mediating health risks is a matter of individual choice (Petersen, 1997, and Robertson, 2000)—is clearly embedded in the ethos of some forms of alternative medicine, the alliance of political right and left groups around the support of alternative medicine reflects the type of political linkages that Beck (1992) suggests emerge around some issues in the risk society (in his example, environmental pollution); these alliances have

the power to challenge dominant methodological systems, such as that of the RCT, which are at the root of proving contemporary allopathic medicine as superior to CAM.

The politics of CAM help to illustrate how the public influences policy as well as how government is in conversation with other sources of institutional power, such as medicine and the sciences, thus providing an example of Foucault's power/knowledge matrix. In this formation, not only is power operating from multiple sources, but the public is actively constructing their own ideas about medicine and health, informed by a risk rationality. As Nettleton (1997) notes:

> For example, it is quite evident that knowledge and information about health and medicine are not simply formulated by medical experts (clinicians, scientists, etc.) and disseminated to a wider audience of health professionals and the public, who in turn accept them as a matter of course. Rather, the knowledge that is generated in these and other locations provides a valuable tool of government at the levels of political discourse, institutions and individuals. Here it may form a valuable dimension of the exercise of power (p. 218).

The power to define what counts as valid medicine is an ongoing, dialectical process. Although I argue that scientists and medical doctors still have the monopoly, this may not always be the case. As the example of CAM illustrates, the public and the government do have a hand in shaping the contours of policy, and this power also has the potential to re-shape a historically dominant institution, such as conventional medicine.

Conclusion

Alternative medicine practices are becoming accepted within the medical community, although as the coverage in the medical journals suggests, there is still some staunch opposition to incorporating CAM into science based medicine. Within the medical and science journals, CAM is constituted as politically meaningful, but paradoxically, CAM's overtly political character marks it as less worthy of funding and scientific attention. Yet, despite differing opinions on its incorporation, the reinforcement of institutional supremacy is maintained through propping up the RCT as the only means by which to test CAM therapies. Finally, alternative medicine is a movement that has political significance for both liberal and conservative lay people; thus, forging an alliance on this common ground enables a momentary linkage to push alternative medicine as a valid means of healing that should be invested in by government funding agencies and insurer reimbursements.

In this chapter, I have shown that the history of alternative health and the politics of women's health have a long relationship. This historical relationship and the rates of women who currently use CAM suggest that women today are a public invested in and subjected to scrutiny as users of CAM. I have provided a glimpse into the professional concerns over the inability of the public, and thus women, to make the correct decision about alternative care, and thus illustrate how women are still placed in a relative position of subordination in relation to conventional medicine. I have also illustrated how the RCT and the ideal of scientific objectivity are constructed as the only means by which CAM

therapies should be tested; thus, even within the debate in the medical community over whether or not CAM therapies should be accepted, the institutional norms of science and objectivity are held up as an ideal that helped to secure medical authority. Finally, I have argued that the debate over the incorporation of CAM into mainstream medical practice is a political issue within the medical community as well as for politicians and lay people. While the journals constitute the public and politicians as anti-science, the ability for the public to come together across party lines in favor of changing the medical landscape provides a potent example of how solidarity can be achieved within reflexive modernity.

In the next chapter, I analyze the discursive construction of CAM in women's popular health media and argue that it is subsumed by lifestyle concerns such as beauty and weight; thus, at times the discursive construction of CAM reinforces patriarchal assumptions about the social importance of outward appearance for women. However, CAM is also discursively constructed in these media in ways that challenge the super-thin ideal that is consistently represented in women's popular media. CAM is thus linked to both regressive and progressive ideologies in women's popular health media.

Chapter Three: "Beauty, Slimness, and Health: The Discursive Construction of Risk in Women's Popular Health Media"

In the previous chapter, I demonstrated how the medical community at large constructs CAM—as a phenomenon that must be carefully circumscribed using the institutional and methodological frameworks of conventional medicine. In this chapter, I explore how women's popular health media represent CAM in order to understand how it is constructed for a wide group of women. This is important in broadening the scope of the project and applying it to gender more concretely. In my analysis of women's popular health media, I found that one of the key ways CAM is discursively constructed is by connecting appearance to health. In this discourse, beauty is constructed as attainable via CAM, in ways that blur the lines between health and appearance: for example, by suggesting beauty may be attained through a healthy lifestyle via the use of supplements, such as vitamin combinations. In addition, these outlets discuss the pursuit of beauty for its own sake as vain and thus a hindrance to personal development. The discursive construction of vanity in these media thus obscures the social norms dictating that beauty is important for women to possess in American culture. Because women's popular health media construct vanity as a moral shortcoming, their articulation of beauty to health in general, and CAM in particular, positions the pursuit of beauty as a valid, *central* pastime in women's lives, this is achieved through these media's recommendations that women participate in routine, scrutinized self-examinations, thus providing guidelines that contribute to disciplinary practices for women and ultimately leads to an intensification

of a normalized image of female health (Foucault, 1977). I argue that articulating CAM to beauty provides a more stringent set of standards for women than even those imperatives from media that frame beauty as a means of empowerment, such as the well-known L'Oreal ads for cosmetics or hair dye featuring beautiful celebrities expressing their signature phrase, "I'm worth it" (Durham, 2009). Moreover, I argue that when women's popular health media articulate physical appearance[xl] to health (often conflating the two), they do so using risk to discursively displace their emphasis on appearance by foregrounding the supposed health benefits and consequences of not monitoring one's physical appearance, including—importantly—slimness.

In addition, the discourse on weight loss presented in these media tend to emphasize diet and exercise as the primary course to good health; thus, the media I analyze also convey a biopolitical imperative when they express concerns about obesity (which concerns the health of the population) at the same time they encourage personal discipline. In order to analyze both the repressive and enabling aspects of weight loss discourse, I will draw from the work of Heyes (2007), who argues that disciplinary strategies of weight loss, while enabling women's capacities for change, growth, and personal achievement in some ways, ultimately co-opt the freedom and liberation promised to women who are highly committed to these practices.

In this chapter, I thus argue that risk discourses in women's popular health media function in two ways. First, risk discursively secures the dominance of beauty and slimness as a cultural value central to femininity, achieved by these media by connecting

conventional beauty standards—such as a youthful appearance, smooth nails, and clear skin—to health, and connect added weight, skin or nail problems to an absence of optimum health or illness. These recommendations therefore encourage disciplinary practices that succeed in making women subjects, not through overt force, but through observation and normalization (Foucault 1977, p. 170). In addition, the media I analyze suggest that living the healthy lifestyle they recommend will mediate health risks and thus engage in what Beck (1992) terms risk displacement: a process by which experts provide supposed remedies to protect people against the negative consequences of risks.

On the other hand, women's popular health media also employ risk discourses as a means to critique unhealthy habits—such as fad dieting—because of the supposed negative effects on health. Thus, a paradox emerges: these media engage reflexively with critiques of the media as perpetuators of a thin body ideal that may motivate fad dieting, while, at the same time they reinforce the importance of a normalized version of the female body for women. This at times can be problematic, because the media's stated concern with women's health obscures the normalized relationship between health and appearance, thus making that discourse more difficult to counter.

In the first section of this chapter, I outline the historical cultural relationship between beauty, health and virtue, and describe how CAM is articulated to appearance by women's popular health media through encouraging women to participate in examining any apparent abnormalities in their appearance. In the next section, I argue that vanity is discussed in women's popular health media as a struggle that women negotiate, thus

speaking to the savvy of women audiences who are aware of the unrealistic standards of beauty presented in the media. In the third part of the chapter, I discuss how women's popular health media connect weight—particularly overweight and obesity—to health using the risk of disease as a motivator to lose weight. Throughout these sections, I illustrate how risk discourses are used to justify self-examination and thus reinforce a normalized female body; in the last section I illustrate how risk also functions in these discourses to provide a critique of fad dieting, with some of this content even discussing the problem of doctors discriminating against their overweight female patients. These media thus reproduce some aspects of patriarchy while at the same time they critique it.

CAM, health, and beauty

I use historian Kathy Peiss' (1998) definition of "beauty culture" in order to explore how beauty has been linked historically to women, health and virtue, and has been a consistent trope across time in American history, continuing into the present. Peiss defines beauty culture, "…not only as a type of commerce but as a system of meaning that helped women navigate the changing conditions of modern social experience" (Peiss, 2008, p. 6). As she argues, women have not only been subjected to beauty standards, but have also used them to actively fashion identities and express rebellion; this process changes historically due to changing political and economic realities. For example, during the 19th century, women in the U.S. both entering the working world and being entrenched in a new "marriage market" (which supplanted traditional forms of courtship) were expressions of women's new social roles. "For women experiencing these social changes,

the act of beautifying often became a lightning rod for larger conflicts over female autonomy and social roles" (Peiss, 1998, p. 7).

As a system of meaning, contemporary beauty culture is inflected in women's popular health media with discourses of health and longevity; as I will discuss further at the end of this section, it also has an economic imperative (by blending beauty, fashion, and health content, media seamlessly create brand identities and present a more unified message to their target markets). One of the reasons articulating appearance to health is problematic is because beauty standards are cultural constructions that have historically functioned to oppress women. As communication health scholar Lebesco (2010) points out, those who do not conform to a slim body are subject to moralizing critiques (often subtly disguised as public health initiatives) of the overweight as being ignorant, lacking self-control or lazy. In addition, because beauty standards have oppressed women, it is important to note that connecting appearance with health is not politically neutral and necessitates further investigation (Peiss, 1998).

For example, as Susan Bordo (1993) points out, the embodied woman has historically been laden with negative associations attributed to the mind-body dualism fundamental to Western philosophical thought. For example, the duality of mind and body has been used historically to justify women's life paths in child-rearing and home-making, constructed as natural expressions of their reproductive capacities, while men were seen as inherently rational and fit for life in the public sphere.

This bias in turn has informed the medical profession's historical assumption that women's bodies are pathological. For example, in addition to women's bodies being constructed as problematic or diseased, medical practitioners and scientists in the 1700s and 1800s used phrenology and physiognomy to connect inner states of being or moral worth and external appearance. Peiss' (1998) discussion of how men and women were characterized in physiognomy and phrenology according to appearance explains the importance beauty held for women. "These pseudosciences classified men in terms of a diverse range of occupations and aptitudes. When it came to women, however their subject was solely beauty and virtue. Thus physical beauty originated not in visual sensation and formal aesthetics but in its 'representative and correspondent' relationship to goodness" (Peiss, 1998, p. 24). As Peiss points out, beauty was not based on formal aesthetics but was simply a construction of those "sciences." Peiss' discussion of how phrenology and physiognomy "scientifically" discovered how appearance was directly connected to inner goodness illustrates how science has been used in the past to justify the oppression of women, minorities, and those with lower class status, and shows how scientific findings must always be considered within their cultural and social context.

Similarly, beauty standards are not static but shift over time (Durham, 2009, Wolf, 2002). As Ehrenreich and English (2005) note, connecting beauty to health has roots in the Victorian Age, where sickly looking, pallid women were set up as a standard of beauty, and a constant state of illness connoted class privilege. Yet, Durham (2009) argues that having a full figure until at least the 1830s (right before the advent of the Victorian Age) was associated with good habits, temperament and health (Durham, 2009,

p. 184). Conversely, today a much thinner form is associated with perceived good health and attractiveness.

Because beauty standards are cultural constructions that change with time; it is neither inevitable nor pre-ordained that the stick thin look will always be the standard for female beauty or will always stand as a symbol for health. In fact, contemporary critiques of waif-thin celebrities seem to be policing the boundaries of thinness and the burgeoning field of fat studies (which has recently generated both an edited volume: *The Fat Studies Reader* ([Rothblum & Solovay, 2009] and an academic journal entitled *Fat Studies*), points to shifting sentiments around the issue of weight and what counts as healthy. These trends point to resistance against the moralizing discourse of the obesity epidemic.

These critiques of thinness are illustrative of reflexivity in late modernity among both academics (where fat studies is an emerging field) and lay populations (in the fat acceptance movements). Despite this reflexive response, the unrealistic beauty and fitness standards that women are expected to live up to are reinforced powerfully in the media through self-examination, which works to secure a normalized ideal of what healthy women's bodies should look like. Indeed, as Foucault (1977) argues, self-surveillance, or the internalization of particular norms and the subsequent monitoring of these norms by subjects (in this case, what counts as visible indicators of health) works to produce certain kinds of subjects (in this example, fit and active citizens) that support and expand social and governmental imperatives (in this example, the anti-obesity epidemic and an emphasis on maintaining youthfulness, both of which promote self-sufficiency).

Media Analysis

In order to provide examples of how women's popular health media present the practice of self-examination as an important indicator from which to assess health, I analyze *The Dr. Oz Show*, *Women's Health Magazine*, and *Prevention* magazine. To analyze Dr. Oz's program, I selected 28 shows from the Fall 2011 season. I chose these shows based on title and description, purposely selecting programs that did *not* deal with beauty or weight loss. I did this so that I could assess the general content in shows that appeared to be about other topics. I chose not to include CAM as a prerequisite in the description because based on my previous experience with the program, CAM elements are incorporated into most episodes.

I also chose to analyze every feature-length (more than two pages) magazine article in 2011 from *Prevention*—which included 12 feature articles (out of 12 issues) that dealt with CAM or that associated beauty, weight and health—and *Women's Health*, which included three articles (out of 10) that dealt with the same topics. In the following section, I detail excerpts from the media I analyzed in order to illustrate how self-examination encourages a disciplinary practice among women and thus constructs a normalized image of the female body at the same time it serves biopolitical imperatives.

Women's Popular Health Media's Construction of the Examination

Media representations that link CAM, health, and appearance often associate a perceived flaw in physical appearance, such as acne or discolored nails, as possible indicators of underlying health problems or a sign that one is not in optimal health. In order to assess

whether or not women may have an underlying illness, these media often recommend they perform a self-examination to observe any possible abnormalities in their own appearance. However, although finding underlying illnesses is often the stated claim of the shows and magazine features I analyze, this coverage typically ends up devolving into beauty advice rather than a discussion of illness; thus the examination functions to perpetuate a normalized standard of female health.

This theme is highlighted on *The Dr. Oz Show* in an episode entitled, "Biggest anti-aging hour ever: no makeup show: what's the real age of your skin?", supposedly devoted to showing how lackluster skin can point to more serious health issues. Oz opens the show by trying to sympathize with his female viewers. In front of an empty studio audience he addresses the camera:

> Before today's show starts, I have a confession to make. I've been hiding behind my makeup. But not today, this is the real me, untouched. Every day before the show, I spend at least 15 minutes putting on makeup to hide the dark circles and bags under my eyes. Just like you, I cover the signs of aging. Makeup covers the flaws you don't want others to see, but as a doctor, I don't want you to miss what your naked face tells you about your health. That's why today, for the first time ever, I'm asking my entire audience to remove their makeup. They don't know it yet; I'm going to tell them. ("Biggest anti-aging hour ever: No makeup show—What's the real age of your skin?, Winfrey, 2011)

Although Oz tries to portray himself as sympathetic to his female audience members, comparing his removal of makeup to that of the women in the audience is clearly not a parallel example, due in no small part to the fact that many women apply makeup every day and have been socialized to do so for gender specific reasons; men, unless they are on television, generally do not use makeup. In this example, the practice of applying make-up, which Bartky (1988) argues is a form of discipline, is stripped of its gender-differentiating context. This is not to say that the practice of applying makeup is necessarily *felt* as disciplinary by the women who perform this ritual; just that as a socialized practice, it constructs female bodies differently than male bodies.

Contrary to Oz's claims about what analyzing makeup-free skin will reveal about health, the "Biggest anti-aging hour ever" episode continues by emphasizing aging skin as a problem and suggesting possible remedies for it, rather than discussing health problems that may be causing skin to appear dull. In this episode, make-up is removed and the examination reveals the "truth" of these women's appearance and, supposedly, health. Oz walks his audience through an examination of their skin and asks his studio audience to hold hand mirrors to examine their make-up free faces, asking them questions such as, "Are your upper eyelids drooping? Almost touching your lower lashes? [and] Do you see smile lines from the corner of your nostrils to the corner of your mouth?" ("Biggest anti-aging hour ever," Winfrey, 2011).

This process clearly illustrates how the normalization of youth as an indicator of health is established through a very detailed examination of the face:

> It [the examination] established over individuals visibility through which one differentiates them and judges them. That is why, in all the mechanisms of discipline, the examination is highly ritualized. In it are combined the ceremony of power and the form of the experiment, the deployment of force and the establishment of truth (Foucault, 1977, p. 184).

As a doctor, Oz has the authority to lead the audience through a series of questions that appear to be diagnostic, implying that this exam has some medical relevance to health. In addition, sagging skin and wrinkles become deviant variations from an ideal norm, thus subtly reinforcing the idea that young looking skin means healthy skin. The medical aspect of the topic is also foregrounded by his expert on the show, a dermatologist, who reiterates the medical importance of good-looking skin. She says:

> Well, I think it's true that your face reflects what's going on in your body and the face is really the thinnest skin in our body, and it's sometimes where we first see changes of health ailments; for some people, [who] might not be getting enough sleep, you're dehydrated, having an allergic reaction, you might see this in your eyes as tiredness, bagginess…so the eyes are really an important window into your health ("Biggest anti-aging hour ever," Winfrey, 2011).

When both of these doctors discuss possible health problems as being apparent on the skin, they not only use the examination to reinforce the normalization of an ideal of appearance for healthy women, they also use risk as a means to validate the connection between the topic and health (since it is being aired on a health talk show). In this

example, risk functions as a discursive means to reinforce the idea that appearance of the skin or nails could signal a health problem; however, because health problems are never really addressed on the episode, there is a clear conflation between youth and health. In addition, the recommendations by the doctors on the show also work as a form of risk displacement, making the audience feel as if they have some measure of control over their health (for example, if their skin looks good, they have no underlying health problem). However, this can be dangerous advice: if a woman who consumes popular health media is diagnosed with a medical condition, she may feel as if she was not vigilant enough in her observance of outward signs of disease.

The stated purpose of Oz's episode—that the skin reflects health—reinforces an ideology that conflates outward physical appearance with health. In their discussion of Gramsci's theory of hegemony, Mumby and Mease (2006) point out that consent is needed in order for subordinate groups to agree with the ideology of the ruling class; once consensus of a subordinate group or groups is attained, ideology becomes masked as common sense. In the example above, the women in the audience agree to go along with Oz's experiment because he assures them it is good for their health—they consent to his dictate, seemingly accepting it as common sense, emanating as it does from a credible source. Thus, not only does the show connect good-looking skin and health, but the ideology of beauty being an important feature for women to possess is reinforced. Similarly, the act of adeptly performing a skin-care regimen and acquiring knowledge about skin, framed within the context of medicine (dermatology), is presented as an important form of knowledge about health.

In another example of how self-examination functions to promote normality on *The Dr. Oz Show*, Oz notes, "Your fingernails could be sending signals that something is wrong inside your body" ("Dr. Oz Takes on the Queen of Southern Cooking," 2011). Oz goes on to discuss how white cracks in the nail or the absence of a crescent in the nail could signal a nutritional deficiency and a dark stripe on the nail could indicate melanoma. One of the reasons this is problematic is because it illustrates how women's popular health media have constructed an increasingly stringent, normative view of the female body to include factors as minute as the shape, pattern, and color of the nails. This micro-analysis of specific body parts thus also requires an increase in self-surveillance and contributes to a more stringent regime of a normalized, healthy body[xli].

When the media articulate health to appearance, the pursuit of beauty assumes a more meaningful urgency than when such an articulation is lacking and they encourage women simply to look better for aesthetic or self-confidence reasons. Even though much of the mainstream media's coverage on beauty's connection to health is related to cosmetic advice, having health as a justifying force behind it boosts appearance as a more credible concern. Indeed, as Wolf (1992) points out, linking beauty with health helped justify the work of cosmetic surgeons, who, she argues, have self-servingly changed the meaning of health for women by connecting it to cosmetic surgery procedures. As cosmetic surgery has become relatively mainstream, women's concerns over the risks of invasive procedures—which have also been highlighted in the media—have made noninvasive options such as Botox and Restylene more attractive to female consumers (in 2011 there were fewer than 500,000 procedures for face lift and rhinoplasty combined,

while there were over 5 million Botox procedures) (Rogers & Vanco, 2012). When beauty is articulated to health through CAM, (for example, if eating certain foods will make one look younger, and exercise will achieve a particular body type as well as mediate the risk of disease), then those disciplinary practices may be more accepted and more widely used by women, and contribute to more women fitting the standard. In this case then, the advice serves a normalizing function by identifying what counts as healthy skin, hair, nails, and figure. “In a sense the power of normalization imposes homogeneity; but it individualizes by making it possible to measure gaps, determine levels, to fix specialties and to render the differences useful by fitting them one to another” (Foucault, p. 184). Therefore, the process of self-examination advocated here may be understood as disciplinary when refracted through the lens of health.

Thomsen (2002) argues that health media may be an important factor in how women perceive their bodies and health. In his research of college-aged women who consumed health media, he found that media was a major sociocultural influence in body perception: those who read health and fitness magazines were more concerned with body shape and image than those who read fashion media (criticized in the mainstream media and by scholars such as Durham [2009] for providing unrealistic body standards for women). Thomsen’s research suggests that women find health media more instructive about body size and shape than fashion media, which were more closely associated with internalizing gender roles: “The specific focus on dieting and body shaping and sculpting found in health and fitness magazine articles and photographs may actually encourage readers to engage in more frequent and intense body-oriented and specific body-part

comparisons…" (p. 1001). This is important because as Fairclough (2001) explains, discourse such as this may influence action: "Discourses, genres, and styles are interconnected through a dialectic of 'rematerialization'—they constitute different semiotic materialities which are connected by the processes of operationalization [ways of acting and interacting], inculcation [as ways of being] and representation [how non-semiotic elements of social practice are represented as discourses]" (p. 29). In other words, Fairclough argues that discourses can affect how people act as well as how they discuss their actions. Similarly, Foucault argues that discourse helps to actively construct subjectivities. Because women's popular health media's representations of women's bodies are instructive to women about body image, it follows that how media articulate the body to health may also be instructive to women in interpreting this connection.

Now that I have discussed how the self-examination works in women's popular health media to encourage disciplinary practices and contribute to the normalization of a healthy female body, in the following section, I provide examples from two women's health magazines—*Prevention* and *Women's Health*—and *The Dr. Oz Show* in order to illustrate how risk discourses function in women's popular health media to mediate concerns over vanity. This illustrates that media producers are aware of the feminist and widespread agreement among women about the unrealistic representations of women's bodies in the media. Such concern is acknowledged by these media, but primarily remains unchallenged.

Women's Popular Health Media's Construction of Vanity

By articulating appearance to CAM through the self-examination, women's popular health media are able to frame beauty as a legitimate health topic. These media also help to construct beauty as naturally attainable through diet and exercise, rather than dependent on applying makeup adeptly or selecting appropriate clothing. In these ways, an emphasis on health supersedes a focus on cosmetic issues, thus making beauty regimens appear to be less indulgent. This is not to say that women are dupes or unaware that beauty regimens endorse a largely unattainable goal of perpetual youth, indeed women have become increasingly critical about unrealistic beauty standards in the media. For example, the now widespread awareness and critique of magazines' and advertiser's photo retouching of models to make them appear as if they have no flaws. When the media I analyzed featured women expressing concerns over vanity, these media deployed risk discourses as a means to mediate those concerns and assure women that beauty maintenance was a worthy pursuit[xlii]. One common way that risk discourse was used to mediate vanity in the media I analyzed, was with suggestions to women that outward appearance could be a signal of underlying ill health (or at least not optimum health), as I argued in the last section.

Before I analyze how concerns over vanity are mediated in these forums, I want to examine the connection to advertising and branding—a connection that contributes to the economic rationale for connecting appearance and health. I will analyze branding further in chapter four; however, as I noted in chapter one, all the media I analyze work

synergistically with one another to cross promote content, and the magazines I analyze, *Prevention* and *Women's Health* both include ads from upscale beauty brands that promote themselves as "natural," such as Aveda. Beauty brands that promote themselves as natural and health media tend to share a target audience so integrating their messages to that audience contributes to a more cohesive message and thus a more effective and lucrative branding strategy for both the beauty brands and the media.

Women's Health provides an exemplary illustration of the synergy between health and beauty media. Michelle Promaulyako, *WH's* executive editor was a former editor at *Cosmopolitan* and has brought her expertise in the fashion and beauty world to the publication. In addition to increasing fashion and beauty advertisements since she arrived she has helped to create an effective brand image for the magazine (Ives, 2009). She has been so successful with this endeavor, that in 2009, *WH* was named Advertising Age's, "Magazine of the Year." In their description of its successful branding strategy the site notes:

> Most magazines say they're brands too, but *Women's Health* is (power) walking the talk. And its other platforms aren't just extensions—they're revenue drivers. Its free website, for example, leads visitors to two of them, Fit Coach and the Abs Diet for Women, which charge membership fees (Ives, 2009, Paragraphs 1 and 2).

As Promaulayko notes in the article, "We have an aggressive content strategy that starts with the magazine and moves across multiple platforms" (Ives, 2009, Paragraph 3). The content I analyze in these media thus works to not just reinforce social norms of

appearance for women but also to extend the fashion and beauty industry into other realms that are only slightly related, such as health; this contributes to a more unified series of images and messages that reinforce a particular normalized version of a healthy female body. What I want to emphasize here is that the trends I describe are not simply ideological; they also point to the creation of an important branding strategy of natural products and CAM therapies that advertisers target to a specific consumer niche. Because of this connection between beauty and health content, it is important for the media I analyze to mediate the concerns of women over the time they spend on beauty regimens, by articulating these regimens to health, they are thus constituted as a worthy pursuit.

Vanity as Vice and the Historical Connection to Race and Class

In the media I analyze, women who articulate concern about vanity are all white, even though the *Dr. Oz Show* has a good number of visible minorities in his audience. Indeed the historical associations with "brazen" make-up application provides a historical context for understanding how white, middle-class women view vanity. As Peiss (1998) notes: "In the nineteenth century, Americans insisted on a fundamental distinction between skin-improving and skin-masking substances" (1998, p. 6). Because of the social distinction in the late 1800s between improving one's appearance subtly and the more brazen makeup application of prostitutes and lower class women, make-up use served to demarcate women from one another as well as prescribed a particular look of naturalness to be achieved with the right products and adept application, a process that was key to visibly defining class differences among women. Indeed, being slim and achieving a

"natural" look is also linked in contemporary times with social class, as those from the working class often have differential access to healthful foods and exercise, as well as have different social expectations for body standards (Lupton, 1994, p. 40). Thus, the recommendations forwarded on Oz's show are class-specific, catering to a white, middle-class standard of beauty. In that sense, these recommendations may be understood as postfeminist: the white, middle-class woman is constructed by the media as representing all women (Vavrus, 2002). Similarly, targeting this group of women speaks to the economic rationale of selling "natural" products across these platforms.

One reason women express concerns over vanity is that they are increasingly aware of the socially constructed nature of beauty norms. In her study that involved interviewing 42 individuals about weight loss and beauty, Kwan (2009) found that they were aware of, and resistant to, unrealistic beauty standards: "unlike health messages—which nearly all participants openly embraced—most participants criticized the cultural beauty ideal, indicating that it is an unattainable, unrealistic, and airbrushed fiction" (p. 1226). Feminist scholars Lisa R. Rubin, Carol J. Nemeroff, and Nancy Felipe Russo (2004) heard similar responses from women they interviewed who were critical of a beauty ideal, but still struggled with feeling as if they were vain. In their study, focus groups of women who discussed body image and appearance and also described themselves as feminists felt that caving to beauty pressures meant that they were inadequate feminists, thus exacerbating their feelings of shame around beauty and body image (Rubin, et. al., 2004). "In fact, the participants described feelings of guilt, or

shame, for being feminist and still 'buying into' cultural and commercial messages about beauty ideals" (Rubin, et. al., 2004, p. 35).

Women expressing concern over being vain seems to be a departure from the media discourse that links beauty to empowerment, which has been critiqued by many feminist scholars (Gill & Arthurs, 2006, and Lazar, 2006). Although there are still plenty of examples in the media of this tendency, expressing concern over appearing vain seems to be a novel trend in contemporary media (though as I pointed out earlier, it has clear historical precedents). In one illustration of this sentiment on his show, Oz asks a white woman in the audience to explain how she struggles with taking off her makeup. She says, "Okay, um, I struggled with it. I do not leave the house without makeup, even on weekends, and I think, uh it's more of a self-confidence thing" ("Biggest anti-aging hour ever", Winfrey, 2011). Oz is quick to point out that the women in the audience feel embarrassed about their attachment to makeup. He asks the audience, "Do you feel shame in the voices of some of the women who are speaking?" ("Biggest anti-aging hour ever," Winfrey, 2011). The woman admits that she does feel embarrassment about her attachment to it. "I hate to say it, but I guess I'm a little vain and appearance is important to me" ("Biggest anti-aging hour ever," Winfrey, 2011).

Once the woman reveals her vanity, Oz responds by claiming that her appearance is also important to him, and indicates the medical dimension of lackluster skin: "As a doctor I'm looking for different things. That's what the show's about today folks. I've asked you all to remove your makeup for a very specific reason: it's important for me to

see your skin, what it looks like, and I want you to see too, because what we're going to do right now is to teach us about what's going on, on your face" ("Biggest anti-aging hour ever," Winfrey, 2011). Oz often claims that whereas appearances may be important to his guests for cosmetic reasons, as a doctor his concern with their weight loss, and, appearance or other cosmetic flaws is purely about health. The program thus marks women as vain as it simultaneously marks Oz as benevolent—a physician whose concerns are justifiable and in his patients' best interest. Oz reassures his audience that there are reasons to be concerned about appearance, but that health, rather than vanity, should be at the root of women's concerns.

Connecting beauty with health is also apparently something that the public gleans from other media as well. For example, Kwan's (2009) interview participants said their perception of body ideals were attained primarily through the media, and viewed health and beauty as intertwined: "That is, cultural representations of beauty, participants felt, embody health" (p. 1228). Therefore, popular media help to form part of the picture of what a healthy person looks like. When the ideal healthy female body is constructed as slim and conventionally attractive, those ideals become even more important to attain.

The construction of women's ambivalence over vanity is also expressed in an April 2012 issue[xliii] of *Women's Health* magazine, where the letter from the editor highlights the contradictory nature of contemporary discourses on vanity. The editor, Michele Promaulayko, opens her musings on the "beauty issue" of the magazine by saying, "I have a complicated relationship with beauty. More specifically, I wrestle with

just how much time and energy I should dedicate to trying to make the package I come in look better than what Mother Nature rolled off the assembly line. I'd love to say I'm above vanity. I'm not" (Promaulayko, 2012, p. 10). Promaulayko goes on to ponder whether she spends sufficient time on her inner self as compared with her beauty regimen, and extols the health benefits of beauty maintenance—such as using perfumes that influence your brain to give you an edge in your professional life, or getting a hair blowout—that may increase confidence. Although pursuing beauty goals to increase self-confidence is not a new theme in the media's construction of beauty, highlighting research that shows beauty regimens' potential physiological effects is. She ends the letter with a contradictory musing:

> I'm going to stop worrying about the hierarchical importance of beautifying versus more erudite tasks. (Besides, fretting causes wrinkles!) Instead, I'm embracing the idea that anything you do that makes you feel calmer, sexier, happier, more polished—whether it's hitting the gym or testing out a bold new hair hue—is time well spent. Just as long as you're content with your content (Promaulayko, 2012, p. 10)

In the same paragraph in which she says worrying causes wrinkles (which is clearly a bad thing to her), Promaulayko encourages women to go to the gym or dye their hair, but then asserts they should be content with how they look, thus contradicting the advice to change hair color or physique, as that would seemingly change one's "content." Her editorial also speaks to how fitness or beauty regimens may be understood as

empowering, which clearly at times, women embrace. Yet, as Heyes (2007) emphasizes, the pervasiveness of an ideal physical form women are encouraged to conform to serves as a background from which it is difficult for women to fully disentangle their enabling capacities from how that image is connected with, and contributes to, disciplinary practices. In her summation of Foucault's account of power and freedom, Heyes notes:

> Freedom, on this [Foucault's] view, is not only a matter of being liberated from the grip of sovereign power, thereby increasing one's autonomy simultaneously with one's capacities. It also consists in grasping a different, much less available picture, within which the development of new capacities is explicitly tied to the growing grasp of disciplinary power on the subject's self-conception (2007, p. 72).

Therefore, while beauty and fitness practices may be enabling for some women in some ways, they are not completely autonomous and liberating. Instead, the image of a healthy female body established in popular health media may limit and restrict the range of available bodies women may possess at the same time engaging in fitness and beauty regimens can be experienced as pleasurable by women.

In addition, the contradictory nature of Promaulayko's musings on beauty and the ambivalence of Oz's audience about removing their makeup are representative of how women's popular health media mediate the guilt they suggest women feel when pursuing beauty ideals. Because some women feel guilty about being "vain" or spending more time on beauty than on other facets of character development, discussing beauty in the

context of health may offer women a way to less self-consciously indulge in beauty regimens if there are perceived health, rather than simply cosmetic, benefits.

In addition to connecting mediating women's concerns over vanity by connecting health to beauty content, the media I analyze also provide remedies to perceived skin, hair, and nail flaws; this advice often involves eating healthy foods or exercising, which are arguably good for overall health. For example, one Dr. Oz show, features a video of a viewer who asks Oz's advice on how to reduce wrinkles. Oz invites Greta to appear on the show, along with Keri Peterson, a contributor to *Women's Health*. Peterson instructs Greta to eat a diet rich in antioxidants including sweet potatoes, red peppers, and almonds and instructs another female viewer to eat a diet high in Omega 3 fatty acids to help make her skin "glow." It is notable that these recommendations to alter diet are based on beauty concerns, yet the foods listed also have known health benefits: research shows that foods rich in antioxidants may lower the chance of getting cancer (National Cancer Center, 2004), and Omega 3 fatty acids benefit LDL cholesterol (The Mayo Clinic, 2012). These foods are also discussed in stories in women's popular health media about how to reduce the chance of disease or lose weight. Therefore, although the segment focuses on beauty concerns, the recommended remedies have total health benefits; in this way, the advice escapes charges of frivolity, as well as avoids recommendations to purchase expensive products for the sole purpose of "vanity."

The nutrition, beauty and weight-loss advice on these shows is also often recycled: in one segment it is beauty advice, whereas in another it serves as diet advice,

and in yet another segment it may be used in episodes that cover how foods can fight disease. Reusing the same content helps editors and show writers easily provide filler for episodes without having to pursue new stories. Finally, Oz's show and the magazines overlap and share content with each other. When Oz features editors and contributors from *Women's Health* and *Prevention* magazines on his show and then appears on the covers of these same and other women's health magazines, their messages about women's health become reinforced and unified.

The above examples illustrate how vanity is mediated in women's popular health media through packaging beauty content as health content. In addition, conflating beauty matters with health concerns may cause beauty issues to seem more pressing than if they were presented absent the health context, while at the same time may relieve women from feeling "guilty" about pursuing beauty for its own sake. The concern over vanity that women seem to be expressing in both *The Dr. Oz Show* and *Women's Health* is also reduced by this conflation, because if being worried about appearance is really being worried about one's health, then it is a worthy pursuit. Indeed, Metzl (2010) makes the same assertion about how the link between appearance and health are unproblematically linked in popular health magazines:

> Calling such language [health magazine features that emphasize appearance] *sexism* or *cultural narcissism* would mobilize a particular critique. But calling it *health* allows these and other magazines to seamlessly construct certain bodies as desirable while relegating others as obscene. The result explicitly justifies

> particular corporeal types and practices, while implicitly suggesting that those who do not play along suffer from ill health. (Metzl, 2010, p. 3).

I argue that CAM has been appropriated by this discourse in a fashion similar to what Metzl describes; yet the way it is constructed in women's popular health media is difficult to critique due its emphasis on healthful foods, moderate exercise, and an alternative form of healing that, as I outlined in chapter one, has explicit historical connections to feminist health movements. How might risk discourses function to secure the primacy of appearance for women? This may be analyzed using CDA; as Fairclough (2001) notes in his description of Stage 3 of the CDA process, one should ask whether the "problem"—in this case, articulating CAM with beauty and slimness—has a function in the social order: "Consider whether the social order (network of practices) in a sense 'needs' the problem; and whether, therefore, the resolution of the problem entails a radical restructuring of the social order" (p. 33). I argue that this articulation has gained prominence in an era when women's social roles within the family are shifting (this is frequently pointed out in the news reports that discuss women's shift to being primary or sole breadwinners in the home). Therefore, maintaining beauty and slimness as a central value associated with femininity becomes more urgent.

Due to women's awareness of the unrealistic standards of beauty represented in the media, the discourse on health helps to make the "problem" of cosmetic issues seem legitimate. Likewise, women's knowledge of the unattainability of representations of beauty in the media is taken into account by media producers glossing over women's

stated concerns about vanity and situating health as the issue at hand. Finally, the economic rationale of branding and cross-promoting beauty, fashion and health content makes sense from a marketing perspective and also contributes to a more normalized image of what a healthy female body looks like. In the next section, I illustrate how women's popular health media discursively use risk to suggest that being overweight or eating unhealthy foods will lead to ill health.

Diet and Weight Loss

The diet and weight loss industry is a booming business. According to a 2008 article from *Bloomberg Business Week*, Americans spend $40 billion a year on weight loss programs and products (Reisner, 2008). Popular media outlets that frequently feature stories on CAM such as *The Dr. Oz Show, WH* and *Prevention*, challenge so-called quick fix weight loss programs or fad diets, and instead encourage a healthy diet and consistent, moderate exercise. In addition, women's health media increasingly demonize "fad diets," although they continue to present diets as a way to improve appearance. However, they tend to frame diets in terms of "lifestyle changes" (such as walking 10,000 steps per day or adding vegetables to one's diet) that can help improve health and mediate the risk of diseases by lowering blood pressure, cholesterol, and blood sugar, rather than losing weight *only* to improve appearance. This has resulted in what Lupton (2002) argues is the medicalization of food (she notes that the media emphasize the relationship between "bad" foods and disastrous health outcomes or the health benefits of eating particular foods, which leads to this medicalization). This tendency is not new, having roots in the

early twentieth century. For example, in her discussion of how physicians of the time considered food to be an important factor in fighting tuberculosis, Craddock (2001) explains, “The point was clear that women needed to make sure their families got the right kinds of foods everyday as one important prevention tactic” (p. 341).

When women’s popular health media discuss each bite of food and step made as a form of health maintenance, they become active in supporting a disciplinary regime that contributes to national and state initiatives aimed at public weight loss and fitness. For example, the National Institute of Health’s (NIH) Obesity Education Initiative (OEI) explains that its primary goal is to, “encourage the adoption of heart healthy eating patterns and physical activity habits that will not only help prevent and reduce the prevalence of overweight and obesity and their related CHD [coronary heart disease] risk factors along with sleep apnea, but also help reduce morbidity and mortality from CHD” (2013, Paragraph 6). The OEI’s mission to reduce obesity related deaths clearly aligns with a biopolitical imperative aimed at the maximization of life, and the reduction of chronic diseases that drive health care costs up (CDC, 2012) and work productivity down (Rodbard, Fox, & Grandy, 2009).

Yet, women may also use the diet and weight loss advice featured in women’s popular health media as a motivator to achieve fitness, health, and appearance goals, thus, the discourse I am discussing here is not monolithically oppressive but is also productive. Dieting, beauty, and exercise regimens discipline bodies at the same time they produce new and desired subjectivities for women. As Heyes (2007) suggests, “To understand

dieting as enabling is also to understand that we have reason to embrace the increases in capacities it permits without acceding to the intensification of disciplinary power it currently requires" (p. 64). Thus, women's popular health media's intensification of norms works to both enable more stringent standards as well as help women realize personal desired outcomes through their enactment of surveillance.

I argue that discourses in women's popular health media that encourage healthy eating and exercise habits is also reliant on risk discourses that highlight the preventive features of healthy food and exercise in maintaining health and preventing disease. The critique of fad dieting found in women's popular health media also illustrates how reflexivity functions to condemn unhealthy habits at the same time it reinforces diet and exercise requirements for women.

Within women's popular health media, losing weight to improve health is constructed as an all-encompassing activity, one that demands a particular lifestyle that mediates the risk of illness or premature death through engaging in particular exercise habits, eating certain foods, attaining a certain amount of sleep, and maintaining a certain level of happiness, all in the quest to increase longevity. "The stimulation provided by mediated images hints at confrontations with existential terrors, through for the most part in such small, 'safe' doses, and so commonly juxtaposed with resolutions—promises of safety, heroism or rescue—that the viewer can sleep sweetly at night" (Seale, 2002, p. 67). Again, because a long life of good quality is posed by women's popular health media as what is at stake, weight loss as a result of these habits is merely framed as a positive

side effect rather than a goal in itself (these outlets also feature articles that discuss how getting enough sleep and exercising, and even happiness, are all important facets in maintaining or achieving a "healthy" weight). This does not mean that this advice is necessarily repressive, indeed some of the recommendations may help women achieve personal goals; yet the close connection between the regulation of such often uncontrollable factors in life (such as amount of sleep and level of happiness) and health may place an undue amount of pressure on women to meet these sometimes arbitrary guidelines. I am not arguing that there is no more media coverage dedicated to weight loss alone, because that type of content certainly abounds. What I am analyzing here is how various women's health media present the quest for longevity and overall health and well-being as one of the most important goals in life—achievable through diet and exercise—while weight loss benefits are presented as a pleasant side effect in the quest to extend life (Heyes, 2007 argues that Weight Watchers members often make similar assertions). To illustrate how the focus on "health" is superseding the focus on slimness in women's popular culture, I address how weight loss is discussed in terms of risk discourses that highlight longevity, the fight against obesity, and other chronic diseases related to being overweight and how those discourses frame "choice" as a simple and straightforward solution to becoming healthy.

The "Problem" of Obesity and Overweight

The shift in women's popular health media from an emphasis on losing weight for appearance to a focus on losing weight to maintain or improve health is not surprising

given the wide scope and publicity of the "obesity epidemic." Critical health scholars such as Oliver (2006) and Gard and Wright (2005) have noted that the obesity epidemic has been cast by public health officials and the medical profession as a public health problem, resulting in the stigmatization of individuals who are overweight—particularly women. This stigmatization of overweight women is reflected in medical research that reinforces problematic assumptions about women's social roles and their weight. One particularly disturbing article published in *PLOS One*, suggests that a lack of housework, laundry, and cooking in contemporary society is the reason for increasing obesity amongst women (Archer, Shook, Thomas, Church, Katzmarzyk, Hebert, McIver, Hand, Lavie & Blair, 2013)[xliv]. This article, published in a peer-reviewed journal that features research from the sciences and medicine, received some heat in the popular media for being sexist, but even the existence of such a study authored by doctors and public health officials illustrates how medicine is socially and culturally contextual. For example, the main point of the study is that women lead more sedentary lifestyles than in the past, and although both sexes used to walk more, women in particular had to engage as well in the physical labor of housework, work that no doubt contributed to calorie-burning. However, the focus on domestic work is problematic because it might be used to support an argument that women should either do more housework (while continuing to work) or that their proper place is in the home. Although overweight men are socially stigmatized (as I discuss at the end of this chapter), doctors stigmatize overweight women even when a woman is only slightly overweight; this same stigma does not kick in for men until they are significantly overweight (Brown, 2011).

Gard and Wright (2005) point out that such biases towards the overweight (and generally lower class) also are manifested in doctors' and public health officials' recommendations to women about how to solve the problem: "the idea that a 'healthy body weight' is a simple matter of people making 'simple' and 'correct' choices is also widespread in the scientific literature" (Gard & Wright, 2005, p. 160). This class-specific recommendation also ignores the difficulty with which even those who have the time and money to exercise and eat well may find this advice difficult to implement.

The medical community's discursive construction of weight and health likewise influences the cultural construction of obesity in the wider world, including the media. Therefore the connection between obesity and overweight to health and disease that is clearly articulated in the medical literature and in government initiatives designed to get citizens to lose weight (such as the OEI) is refracted through the media, thus the media contributes to these biopolitical imperatives, that blur the lines between health and weight. While obesity and overweight have been shown to be a risk factor for many diseases, it is important to note that there has been little research that shows a cause and effect relationship between being overweight and disease. As Heyes (2007) points out:

> But the great reduction of this debate [effects of overweight and obesity on health] is the assumption that weight itself is a stand-in for health, with the corollary false beliefs that losing weight automatically solves health problems, and that gaining weight (or being heavier than a stipulated maximum all along) automatically creates them (p. 68).

For example, the connection between being overweight and disease may be more closely related to the consequences of a sedentary lifestyle and the consumption of high sugar and fat foods (which contribute to being overweight) but how they work to cause or influence disease is poorly understood; as Heyes (2007) points out, this does not account for overweight individuals who might otherwise lead a healthy, active lifestyle *and* may also be overweight. For example, according to the National Cancer Institute (2012), most associations between cancer and obesity are based on observational studies, not RCTs. As I argued in the last chapter, just because a study does not use the RCT does not mean that a given treatment is ineffective, but it illustrates how one issue based on observational studies (such as the relationship between being overweight and disease) may be accepted as common sense within the medical community while CAM therapies based on such studies are routinely subject to greater scrutiny. What I am trying to illustrate here is that there are *social* and *political*, rather than purely objective reasons for some health issues being framed as legitimate by doctors and the media while others are not.

The connection between being overweight and health in the media also seems to influence how people who are seeking to lose weight understand their rationale for weight loss. In her semi-structured interviews of 42 individuals who wanted to lose weight, Kwan (2009) found that participants overwhelmingly cited health along with reducing the risk of disease or premature death as a reason to lose weight: “Thus, when asked why they desired weight loss, nearly all participants, regardless of race, gender, or weight category, cited health as a key motivator. Recurring themes included the fear of early death or developing heart disease, along with an awareness that diabetes or some

other health concern ‘runs in the family’—an oft used phrase” (p. 1225). In Kwan’s analysis, the discourses about the obesity epidemic circulated by the medical community and the media have influenced how those who want to lose weight discursively construct their own experience of weight loss (Heyes 2007, makes a similar assertion about how Weight Watchers members named health as a key factor for losing weight).

Heyes (2007) also argues that a focus on health and longevity in relation to weight loss is now more fashionable than simply wanting to look better; indeed, as she points out, there is something about expressing a desire to lose weight simply in order to look good that she notes may sound political alarm bells to some feminists. Meanwhile, weight loss organizations (and the media I analyze as well) focus on what women are *enabled* to do when they lose weight, such as being more active with family members or improving self-esteem. Thus, the discourse on health that emphasizes enabling capacities seems more enlightened, empowering, and even feminist to women. Through the expansion of choice, weight loss discourses expand women’s freedoms, inviting women to be agents of personal development, self-improvement, and health. However, these behaviors also construct certain types of bodies that fit within the biopolitical rationality of the public health discourse of the obesity epidemic at the same time they construct a normalized version of what a healthy woman should look like.

In the following section, I will outline how women’s popular health media use “choice” as a solution to losing weight and eating better, thus suggesting women choose whether to be healthy or not. Framing health as a choice achievable through diet and

exercise means that making choices about diet and exercise may be empowering at the same time they may make women feel as if they have an illusory sense of control over their health.

Individual Choice as a Mediator of Health Risks

The media frequently emphasize individual choices as the solution to weight loss, and thus, better health. For example, in a show entitled, "Defy your age diet," Oz addresses mid-life weight gain as a phenomenon that is destroying women's lives; at first he absolves women of responsibility for it by attributing extra weight in mid-life to declining estrogen, thus displacing individual choice as the most important factor in weight gain. He opens the show with a bold statement, "Today, I am taking on the thing that frightens you most: mid-life weight gain" ("Defy your age diet," Winfrey, 2011). His narration of women's apparent greatest fear is not only patronizing, but also exacerbates this manufactured crisis around aging and possible weight gain. Oz then offers advice for weight loss for every "middle-aged" decade, which includes the 30s, 40s, and 50s. The segment opens with a video montage of women from each of the aforementioned decades discussing their struggles to combat weight gain as they age.

The first woman, Lisa, is 53-years old, white, and not slim by conventional media standards. The video shows Lisa in her home surrounded by family, standing on a scale and preparing food, as she says, "I can handle the mood swings and the hot flashes, but not this weight gain! Once I turned 50, it is impossible to lose weight. I'm tired of depriving myself and exercising when I'm tired. Maybe I should just be content; it is

what it is" ("Defy your age diet," Winfrey, 2011). Following the montage, Lisa appears with Oz, who encourages her not to be satisfied with her current weight. Oz shows Lisa and the audience how their bodies burn 200 fewer calories per day when they are in their 50s as when they were in their 30s. Lisa accompanies Oz to a large screen simulation where he shows her a graphic of the ovaries and how their decreased production of estrogen leads to less efficient calorie burning over the course of a woman's life. While this part of the segment displaces personal responsibility for weight gain, it also serves to further medicalize aging and contributes to an ideology that makes youth a necessary component of women's attractiveness.

In addition, it relies on the rhetoric of choice, because in the next segment Oz's emphasis is on how women can take control of weight gain by supplementing their diet with alternative forms of estrogen. Notably, instead of recommending a pharmacological remedy—which has been the subject of controversy since the findings of the negative effects of HRT therapy—Oz instructs Lisa and the viewers to consume flax seeds. He proceeds to demonstrate how to make a "sinless" watermelon split, which consists of watermelon, Greek yogurt (instead of ice cream), and the miracle ingredient: flax seeds. Ultimately, Oz's recommendation does not significantly challenge the rhetoric of individual choice to lose weight; but the biomedical reasoning he uses suggests that losing weight may be harder for some individuals than others due to hormones: a factor difficult to control. While Oz encourages Lisa to not be "content" with her weight, his description of decreased calorie-burning as she ages also means that as women get older they must continuously restrict food or increase exercise to maintain the same weight.

Thus, the disciplinary practices enacted to control weight may not be experienced as freeing, but rather as one more form of restriction.

For example, in one such segment on fatty liver disease, Dr. Oz emphasizes the risk of unhealthy foods to a black female audience member as not just cosmetic, but potentially fatal. He tells the woman that she should not eat doughnuts, and suggests to her that she think of eating doughnuts as a potentially catastrophic blow to her health. “So don’t think about it as just a little bit of fat on your thighs. Think about it as a toxic event in your liver that will change your life,” (“Defy your age diet,” Winfrey, 2011). When Oz tells her that she should think of eating a doughnut as killing her liver, he is not only undermining a balanced approach to eating (because in most balanced eating plans it is okay to occasionally eat a “bad” food), but he is also instructing viewers on how they should think about which choices they make about food: namely, that choosing the wrong foods may be catastrophic to health. In her explanation of how dieting may be enabling at the same time it is repressive for women, Heyes (2007) points out:

> There can be plenty of joy in eating the “healthy” foods that are too often consumed out of a sense of duty, and the ubiquity of (and pressures to consume) poor quality food in the oversupplied Western countries represent their own challenge to cultural, economic, and social practices. Ultimately, however, dieting is of necessity preoccupied with the refusal of certain foods, or the combinations or quantities of food that please and satiate; it is a practice of self-surveillance that may in one sense improve one’s eating habits, but must also defer some of the

> harmless pleasures of food and drink in favor of projected slenderness. There is no recklessness, no abandon, and no playfulness here. That is not to say that gluttony is a feminist virtue, but as long as the denial of pleasure is so deeply inscribed in the cultural meanings of Western femininity, we should be very skeptical about attempts to further limit what women may enjoy (p. 86-87).

Some foods are thus constructed as "risky" (like doughnuts), while some are safe, contributing to the experience of self-denial that Heyes (2007) argues women have so commonly experienced as dieters seeking to conform to a slender standard.

Again, Oz's construction of being overweight as a health crisis works to reinforce dominant media standards of slimness at the same time it reinforces medical and scientific reasoning for eating certain foods. In this segment, Oz also does not sufficiently discuss the risks of fatty liver disease to the audience, as not everyone is equally at risk (The Mayo Clinic, 2012). In fact, according to the Mayo Clinic, one of the risk factors for nonalcoholic fatty liver disease is losing weight *too quickly*. Although Oz is not endorsing quick-fix weight loss, there is an irony in the way that he has selected overeating as the primary issue of concern, while ignoring other important risk factors for the problem.

Regardless of any viewer's risk factor for disease, the message to always choose healthy foods and exercise provides an illusory sense of control over one's health. As Kirkland (2010) asserts, totally alleviating health risks is impossible, as even those who always make health decisions based on expert advice may still fall ill; thus Oz (and other

popular women's health media) paints risk both as highly manageable, but also, conversely, unpredictable—something that can strike anyone at any time[xlv]. Kirkland comments: "Total self-care and independence is an illusion, inflating the sense of entitlement of those who think they have achieved it, causing unbearable stress on those who can barely achieve it, and leaving only second-class citizenship for those who cannot achieve it at all" (Kirkland, 2010, p. 199). Thus, popular women's health media contribute both to discourses that suggest risk may be managed as a means to promote health, and conversely, to discourses that highlight stories of those who fall ill with no risk factors (Brody, 2012), and that remind us no one is safe from health risks (Chen, 2011).

One article that highlights the paradox of living a healthy lifestyle while still being at risk is featured in *Prevention*. The article, entitled "Lose Weight, No Sweat," discusses exercise as a means not just to slim down (as the title implies), but as a means to boost longevity. The article's introduction highlights the possible scary consequences of inactivity:

> The biggest health hazard you're up against just might be a chair--or a couch or recliner--and all the time you spend sitting in it. Desk jobs, long commutes, too much TV time--all that inactivity our daily routines dictate--is about as bad for us and as fattening as a steady diet of bacon and bread. And despite what you might think, slipping on sneaks for daily sweat sessions alone isn't enough to combat the slow slide toward sickness. According to a study published in the *American*

> *Journal of Epidemiology*, women who sat for more than 6 hours each day had a 37% increased risk of premature death, compared with women who sat for less than 3—regardless of how often they hopped on a treadmill. Nearly all of us are at risk. The average American spends more than 8 hours each day with his or her rear glued to a desk chair, car seat, or couch, according to the American College of Sports Medicine. (Cassity, 2011, Paragraph 1)

The article goes on to state that being sedentary not only slows metabolism, but increases blood sugar and cholesterol and can lead to diabetes, heart disease and a variety of cancers. The article highlights the importance of both routinely exercising and changing lifestyles to decrease the risk of death, and, as a side benefit, to lose weight:

> It requires you to rethink all your habits and find new, more active ways to get through your day, like walking into Starbucks instead of sitting in the drive-thru. If you move enough, you can offset the danger of all the sitting you can't avoid. Bonus: You can burn up to 1,000 calories a day, without ever setting foot in the gym. (Cassity, 2011, Paragraph 4).

This article is typical of the way that stories on weight loss are framed in these media: not just as losing weight for its own sake, but as a way to potentially save your life—with weight loss as an added perk. However, the article also highlights that regardless of how often you exercise, it is never enough to mediate the risk of disease or death. Risk thus functions in this example to suggest hidden factors could be undermining health, even if one tries to be healthy by exercising or eating healthfully.

Such health risks are thus framed by women's popular health media as an ever present danger, one that must be controlled[xlvi]. Therefore, suggestions to eat healthfully and exercise, like in the discourse on beauty, serve as a means of risk displacement—a way to help the audience feel as if they have some measure of control—at the same time they encourage women to be active agents in this process by providing tips on diet and exercise that may help women feel empowered if they achieve personal weight loss goals. Finally, this advice is also profoundly classed. Both Dubrwiny (2013) and Wolf (1999) point out the choices that women make are not equally accessible to all women. In the case of food, this extends to the cost of getting healthful foods, the time needed to prepare healthful meals, and the social acceptance of such foods within one's community.

The above example illustrates how risk is deployed as a major trope in women's health media, by discussing weight-loss as a means to save lives and lessen disease risk. While Beck published his risk society thesis in 1992, and health scholars have been talking about risk discourses in health communication since at least the mid to late 1990s (Skolbekken, 1995 and Petersen, 1997), perhaps its influence was not quite as widespread in women's popular health media before this time. For example, in one article virtually identical to the one I discussed above and, published nearly 10 years earlier in *Prevention*, the author approaches the topic from a much different perspective, exclusively focusing on losing weight as the goal:

> Remember when you had to walk into the gas station to pay? When delivery pizza wasn't an option? When you mowed your own lawn? When you had to get off the

> couch to change the channel? These are just a few of the tasks that are becoming obsolete and depriving us of physical activity. If you add up all the extra calories you could burn just from doing a few things that involve actually moving, you could lose up to 38 lbs. in a year! (Krucoff, 2002, Paragraph 2)

Although both articles focus on the problem of a sedentary lifestyle, the more recent article uses language that discusses being active in life and death terms, whereas the second article much more airily describes being active as a means to lose weight. Comparing these passages illustrates not only how risk proliferates as an informing component of health discourse, but also alludes to how new markets are created for the "lifestyle" problems of modernity:

> Far from being just critique, the demonstration of the hazards and risks of modernization is also an *economic development factor of the first rank*. This becomes all too clear in the development of the various branches of the economy, and equally in the increasing public expenditures for environmental protection, for combating the diseases of civilization and so forth. (Beck, 1992, p. 56)

Beck's insight is important here because one of the "diseases of civilization" he alludes to, I would argue, includes obesity and sedentary lifestyle. Two interrelated problems that have received a large amount of media attention, generated government initiatives[xlvii], and commentary from the medical community[xlviii], thus creating new markets for disease mediation. In addition to creating these new markets, this discourse also emphasizes the importance of being hyper-vigilant about the apparent health risks of a sedentary

lifestyle. For example, one may *look* slim but at the same time be harboring potential diseases beneath the surface of the skin. Thus, the discourse of health risks encompasses increasing areas of contemporary life, as Rose (2001) argues.

In the next section, I discuss how women's popular health media respond to fad dieting and gender discrimination among overweight women in health care to illustrate that the discourses that emphasize slimness are not monolithic. Instead women's popular health media critique these unrealistic standards thus illustrating that they engage with women's awareness of the social stigma of being overweight.

Reflexivity in Women's Popular Health Media

Although the emphasis on disciplined eating is a hallmark of the women's media I analyzed, investigation and debunking of fad diets also appear there[xlix]. In fact, an ongoing segment in *Prevention* debunks or finds the "truth" about the efficacy of new diet plans by analyzing a diet's claim, and then countering it with a commentary on the diet from a spokesperson from the American Dietetic Association. One such segment, featured in an August, 2011, issue reviews a book entitled, "17 Days until Skinny: A Simple Plan That Targets Both Belly Fat and Visceral Fat and Produces Fast Results That Last!"" by Dr. Mike Moreno. The focus of the review is to challenge Dr. Moreno's claim that severely restricting calories will confuse the metabolism into working more efficiently. The diet claim is countered by what is labeled as "fact" from an American Dietetic Association spokesperson, who claims that Dr. Moreno's plan is unhealthy. In another July 2011 segment, another "fad diet" is exposed as fraudulent. A high-protein

diet designed by French doctor Pierre Dukan is tested by the American Dietetic Association and found to be unhealthy; the ADA spokesperson notes that any diet that lacks produce and whole grains—which we need to "ward off diseases, including cancer,"—is not a good plan to follow. The spokesperson's final word on the diet is that following it will give you "constipation, low energy, brain fog, and bad breath" (Manning, 2011, Paragraph 3).

These articles, as well as features on *The Dr. Oz Show*, repeatedly highlight the inefficiency and danger of quick fix plans. In addition, risk discourses about fad diets also encourage a moderate approach to lifestyle and weight loss instead of diets (because they can be risky to health) and may be positive in that they encourage a more balanced approach to eating that does not involve severe food restriction. However, these recommendations tend to include eating foods and taking supplements that are difficult to find or are unaffordable for many people. Although Dr. Oz makes an effort to consider his audience's budget (for example, he has done shows exclusively devoted to how to eat healthfully on a budget) and often recommends affordable alternatives to expensive treatments or products, he still recommends a staggering amount of supplements for minor supposed physical flaws such as wrinkles, dull hair, or weight loss; if audience members followed all of his advice, they would be taking an extremely large volume of supplements and spending an exorbitant amount of money on them.

Although constructing weight loss that results from lifestyle changes rather than extreme dieting may have some benefits for women by challenging stringent and

ineffective dieting recommendations, overweight women are still discussed rather ambivalently in women's popular health media. One article that explores a movement called HAES (Health at Every Size)—a health focused program that excludes weight as a consideration of health—profiles it as "controversial." In the August 2011 *Prevention* feature story, the author describes the HAES movement as one that encourages overweight women to eat intuitively and focus on overall health rather than weight loss. Although the article offers some positive feedback about the program, its introduction paints a comical picture of the women who participate in it. "The pulse of tribal drumming fills the air. Jeannie Troy, 48 and 220 pounds, dances wildly, pogo-ing like a punk rocker at a Green Day concert and shaking her sweaty hair. All around her, women--whose body sizes range from average to well over 300 pounds--grin as they get their groove on" (Ingall, 2011, Paragraph 1). This portrait of overweight women dancing with abandon is followed up by a stern warning by a doctor from Columbia University that being overweight does, in fact, increase risk for several diseases, and thus the HAES program is doing little for the health of the participants. Yet, while the article discusses the "controversy" over whether people should subscribe to the program, it centers the debate on weight loss as a health benefit rather than a beauty concern, thus making a strong connection between health and weight.

The women's health media coverage that I have detailed so far has illustrated the increasingly central place that beauty and being slim or normal weight occupy—and particularly when it is articulated to health, and, importantly, to CAM as well. However, one article in my sample offered a critique of institutionalized medicine by highlighting

the fact that women who are overweight are often discriminated against by their doctors. This article, from the July 2011 issue of *Prevention*, addresses how doctors' negative perceptions of their overweight patients could potentially affect women's healthcare. The article's exposé tone seems contradictory given the heavy emphasis in women's health media about the ways in which extra fat is detrimental to health. The article begins by detailing an overweight patient's experience in a doctor's office where a twisted ankle was attributed to her extra weight. Although the woman tried to tell her doctor that her twisted ankle was not due to her weight, she was simply written off; Brown asserts that, "Her experience is shockingly common" (2011, Paragraph 3). The article notes that "weight stigma" is on the rise in America, and that "ironically" it is deeply rooted among health care providers. A study conducted by the University of Pennsylvania cited in the article showed that more than half of 620 primary care physicians studied labeled their obese patients as "'awkward,' unattractive,' 'ugly,' and 'noncompliant'" to their recommendations (Brown, 2011, Paragraph 3). However, given the emphasis on weight as an indicator of health in both the medical community and the popular media, the responses given are consistent with the wider discourses on obesity.

The article goes on to discuss gender discrimination as a factor in doctors' prejudices, and cites a study from Yale University that found that physicians started to negatively characterize female patients when they were as few as 13 pounds overweight, whereas the weight bias for men didn't activate until the men were around 75 pounds overweight. This article illustrates reflexivity, as well as speaks to the flexibility of hegemony:

> …a particular social structuring of semiotic difference may become hegemonic, become part of the legitimizing common sense which sustains relations of domination, but hegemony will always be contested to a greater or lesser extent, in hegemonic struggle. An order of discourse is not a closed or rigid system, but rather an open one, which can be put at risk by what happens in actual interactions. (Fairclough, 2001, p. 29)

The experience of the woman patient who was discriminated against, and the biases of the doctors featured in this article therefore, work to illuminate the ideology of slimness as important for women to possess; however, the ideology of slimness in relation to health is also reinforced through this publication, thus working to perpetuate this ideology. This example illustrates that although all coverage in the popular media is not uncritical, the rare article that shows a critical slant does not necessarily displace the dominant perspective. The article on weight and gender discrimination does highlight discrepancies in care for women and those who are overweight; however, because the main emphasis in popular discourses on health focus on how being overweight is unhealthy, it is not surprising that doctors harbor a bias against overweight patients.

Conclusion

In this chapter, I have argued that women's popular health media's articulation of CAM to appearance and weight loss provides a stringent, normalizing ideal that women are expected to meet in order to look and feel as if they are "healthy". These discourses emphasize health and use risk discourses to suggest that health risks mays be mediated by

weight loss or diet, a concept that also has historical roots in the early twentieth century. Therefore, making the right choices about food and exercise becomes an increasingly important choice for women to make.

The coverage that emphasizes women's concerns about being vain because they subscribe to conventional beauty standards is mediated through beauty's articulation to health, which may allow women to feel they can indulge in subscribing to beauty standards without feeling guilty about it. In addition, these media outlets illustrate reflexivity; this reflexivity is illustrated through media producers' awareness of unrealistic media beauty standards, articulated as "vanity," which they then confront and accommodate by linking beauty with health, thereby retaining beauty as an important feature for women. In addition, they engage reflexively with critiques of institutional medicine through their coverage of gender discrimination in healthcare, thus illustrating a fluid and contradictory ideology about women's appearance and health.

I have also argued that discourses on weight loss are much more closely articulated to health than to weight loss for its own sake, in part because of the recent media coverage on the obesity epidemic. The coverage on weight loss expresses a biopolitical imperative by emphasizing longevity and the mediation of risk rather than personal or appearance-based reasons to lose weight. The media I analyzed also emphasize moderate eating and exercise habits and use the discourse of risk as a means to warn women against fad dieting and its attendant health dangers. Although such loosening of stringent dieting plans for women may be a positive outcome for women's

health, the assertion that a small amount of extra weight is a potential health crisis serves as a strong, gendered disciplinary force.

However, these discourses also offer points of resistance, particularly the articles on gender discrimination in healthcare and on debunking fad diets; these illustrate that women's popular health media can critique patriarchal structures, but will only go so far—and no further—in doing so. These threads do not fundamentally alter the patriarchal assumptions that underlie the articulation of beauty and slimness to health, but instead provide insight into how the popular media offer relevant critiques of institutional inequities (though whether these stories displace the ideology of beauty and slimness as centrally important to the social acceptance of women is questionable). In the next chapter, I will explore this question more fully by uncovering moments of reflexivity in women's popular health media that challenge the patriarchy of conventional medicine. I will also show how this reflexivity is, in part, a result of the public's critique of conventional doctors. Then, I will discuss how Dr. Oz uses this critique to respond to patient concerns, thus bolstering his brand at the same time his show provides a forum for critiquing conventional medicine.

Chapter Four: Reflexive Modernity and Social Change in Women's Popular Health Media

Feminist media scholars have critiqued the individualistic and consumer-oriented focus of women's popular media (Gill, 2007) and how they objectify women (Durham, 2009). Other media scholars have questioned the ability of mass media to provide any meaningful social critique (Bagdikian, 2004). However, Beck (1992) situates the media as important sites for instigating social change. He argues that while the media exist in a profit-motivated structure they also participate in challenging dominant social institutions such as science and medicine, and thus create forums where social critiques are voiced (Beck, 1992). The site I analyze—women's popular health media—is no different. I argue that there are moments in which these media critique the dominant values and patriarchal ideologies of conventional medicine by articulating concerns about how patriarchy functions in healthcare, for example, in their coverage of gender discrimination. These critiques somewhat displace the individualistic focus that is both a hallmark of health information circulated in the media (Dubriwny, 2013) and what Beck (1992) argues, is precisely what allows for reflexivity in late modernity[1].

In the previous chapters, I established that the way risk functions discursively in medical journals and the media fosters problematic assumptions about women and also focuses on individual action to the exclusion of social action in order to mediate health risks. This trend is an overarching problem with women's health policy and the representations of women's health issues in general (Dubriwny, 2013). However,

women's popular health media also provide examples of reflexivity toward dominant institutions such as medicine and challenge some of this individualized focus as well as the unquestioned expertise of doctors. Yet, reflexivity is also used by Dr. Oz to enhance his brand; this helps to situate Oz as a hero doctor, which is problematic given that his program contributes to the conflation of health with outward appearance. In this chapter, I cover three examples in women's popular health media that illustrate reflexivity: 1) women's popular health media's discussion of the placebo effect; 2) *The Dr. Oz Show's* coverage of chronic pain, where gender oppression in medicine is openly discussed; and 3) Dr. Oz's giving guidance to audience members on how to be reflexive, critical, and skeptical of conventional doctors and medicine. In the latter example, this reflexivity also serves to reinforce his brand: a caring, compassionate, CAM-friendly, and accessible doctor, qualities that run counter to the construction of a cold, disconnected expert that has been critiqued by the mass media. I argue that these media stories that are skeptical of science and medicine feed public distrust of these institutions and thus exemplify one reason why CAM is experiencing such popularity at this time. Finally, I explore how Oz engages with his audience in the position of both expert and patient advocate, thus securing a place of authority that is difficult to challenge. Before I proceed, I first briefly revisit reflexivity (which I defined in the introduction) more extensively with a focus on how it functions in the media.

Reflexivity and Media

Beck (1992) does not extensively theorize how reflexivity functions in the media (Cottle, 1998), yet he does argue the media are important sites for illuminating the contingency of knowledge in late modernity. Thus, as Cottle (1998) suggests, media scholars should use his work more extensively with grounded studies to further elaborate Beck's broad theoretical contribution.

However, critics of Beck's (1992) and Gidden's (1999) theory of reflexivity argue that this concept is not new, but simply modernist, and takes for granted that humans are agential subjects in knowledge production (Han, 2010 discusses this in the context of new media such as blogs). These critiques do not displace the argument I am making: I agree with Beck that late modernity is an appropriate framework from which to examine health information in the media. Similarly, television and magazines are materially different from new media and still operate in a somewhat stable format (though they are supplemented and informed by how users engage with interactive media content on their websites). Finally, I do not wish to dispense with the notion of agency because the stakes in communicating health demand that agency be theorized. Likewise, in this chapter, I show how agency is enacted by women who articulate critiques of conventional medicine in women's popular health media.

Although I argue that the media are important forums for voicing reflexivity, I do not claim that when the media engage in this critique that this fundamentally alters social knowledge. Instead, I agree with van Loon (2000):

> With the information overload and the growing speed of events, we have already been displaced by an ensemble of apparatuses which select and control the risks we should attend to. Reflexivity in a virtual reality is thus not a matter of comprehension (reflectivity) but of selectively connecting to “matters”, to make and keep them “present”, even if only for an instant. (van Loon, 2000, p. 173)

Van Loon’s observation illuminates an important point: stories in the media that express skepticism about medicine may be—and often are—replaced quickly with a new and different take. However, they do make present, at least for a moment, important social issues and may leave a mark on the institutions they critique.

Yet it is difficult for the media to adequately report on risks meaningfully and then suggest actions to be taken to prevent them, given the competing knowledge claims by medical experts and scientists. Van Loon elaborates on this point below:

> In the language of risk, chaos and complexity function as problems which in turn can be used to mobilize resources to reduce their (unknown) predicaments. However, the relationship between the unknown predications and the identified ‘need’ to control or limit them, is paradoxical if not contradictory. For how can something be controlled if it is not known? Consequently, information and communication technologies mobilized to render the unknown more visible have been instrumental in the very proliferation of risks. The uncertainty of futures marked by chaos and complexity thus results in a techno-social configuration in

> which the human is increasingly displaced by his/her own instrumentalism and desire for mastery. (2000, p. 173)

Van Loon's astute observation helps to illuminate the problems I touched on in previous chapters about the difficulty of sufficiently communicating knowledge about risks. However, in the following sections I argue *not* that reflexivity displaces the contingency of knowledge in the risk society, but that at particular moments reflexive criticism of powerful institutions such as conventional medicine, calls into question the dominance of scientific knowledge and the power position of doctors. Whether or not these critiques materialize as social movements, and whether those social movements achieve meaningful change remains to be seen. However, the fact that these resistances are there means that they *could* incite social change and in some cases media stories about health risks *have* resulted in change. For example, stories in the media on Bisphenol-A (BPA) a chemical found in plastics that can cause health problems in humans has resulted in proposed legislation to label all packages with products that contain the chemical (Kerlin, 2013). In addition, many children's bottles and food packages no longer contain it[li].

Women's Talk Media and Social Change

Although *The Dr. Oz Show* may not seem to be a logical place for the public to engage with health politics, as Jane Shattuc's (1999) article on talk shows and the public sphere suggests, talk television has become a common place from which politics are broached. Ouellette (2012) also points out the importance of television in addressing and mobilizing change for social problems: "commercial television has emerged as a visible platform for

mobilizing resources and activating capacities to solve problems from homelessness to environmental destruction" (2012, p. 57).

Talk television is no less valid a format for advancing social change than more elite forms of communication about politics such as reading newspapers. Shattuc notes that the popular press often waxes nostalgic for a public sphere ideal that is untainted by "commercial pressures for 'entertainment'" (Shattuc 1999, 170). However, in the current political climate the line between politics and entertainment is increasingly blurred as debates between candidates become more focused on their personal lives and candidates increasingly use marketing language to describe their campaigns. According to a May 2012 article in an issue of the *Atlantic Magazine* entitled "The Culture Issue," editor James Bennet describes this phenomenon:

> From mass marketing it was a short hop along Madison Avenue to politics. Politicians and their strategists now talk freely about a candidate's "brand," with no notion that they might sound as if they are selling soap, and with no detail too trivial to need attention. ('My brand is hair up, isn't it," Sarah Palin asked John McCain's media strategist in 2008, according to the book *Game Change*). (Bennet, 2012, p. 8)[lii]

Yet, rather than cheapen the political process, incorporating politics into popular culture may allow it to be more readily accessible to a wider range of audiences, including the working class and women. For example, feminist critics have historically been suspicious of the public sphere—private sphere divide that trivializes the private because it has

traditionally been associated with women (Shattuc, 1999, p. 171). Likewise, I argue that women's popular health media such as *The Dr. Oz Show, Women's Health* and *Prevention* magazine, should be considered viable platforms for contributing to social change in health and medicine. In the next section, I provide an example of how women's popular health media engage in reflexive critique of scientific methodologies through their discussion of the placebo effect (two of the magazines I analyzed discussed it). One article also includes a critique of pharmaceutical corporations, which is echoed on *The Dr. Oz Show*. These examples illustrate media producer's skepticism of medical institutions and medical methodologies, which, when circulated in a widely available public format, then become a part of mainstream discourse.

The Placebo Effect

In chapter two, I detailed how medical journals protect institutional authority and position conventional medicine as superior to alternative medicine through their discussion of the Randomized Control Trial (RCT) in testing all medical therapies, including CAM. A good part of this discussion touched on the placebo effect. In these articles authors tended to argue that the placebo effect was "proof" that a problem was psychological rather than physical, thus invalidating its importance. However, in women's popular health media, I found that the placebo effect was dealt with more complexly; both articles advanced CAM as important to women's health and one article questioned scientific assumptions about the placebo effect. In this section I analyze articles that discuss the placebo effect[liii] from both *Women's Health* and *Prevention* magazine and argue that their discussion

provides important insight into how women's health media challenge conventional medicine and center subjective experience as important in healing.

While some proponents of CAM in the medical journals I analyzed argue that those therapies that show evidence only of the placebo effect should be abandoned (Fontanarosa & Lundberg, 1998), supporters in the journals find no problem with the possibility that the placebo effect plays some role in the efficacy of CAM therapies (Chan, 2008). To these supporters, the fact that the placebo effect works proves a strong mind-body connection in the process of healing and thus challenges conventional ways of practicing medicine that focus on the absence of disease (Lock, 1998). The placebo effect does not just play a role in CAM, but has been proven powerfully effective in conventional treatments as well (Welch, 2003), a fact not sufficiently explored in the medical and scientific journals I analyzed in this dissertation.

The popular media I reviewed were more open to exploring the placebo effect. A *WH* article that explores the topic, for example, explicates how it works and argues that if the placebo effect improves outcomes for patients, it is indeed a valid treatment. In the article, entitled, "Fake Pill, Real power," the author claims that *WH* has unlocked the mystery of the placebo effect and will help readers harness their mental abilities to manage pain. The article traces the history of the placebo effect beginning with Scottish physician, Dr. William Cullen, who in the 1700s was working with patients suffering from smallpox and typhoid. The article claims the power of the placebo effect was established as "scientific fact" when a surgeon in 1955, Henry Beecher, proved that a

third of patients could be cured by it. The article also provides additional evidence to prove its claims, citing a "famous study" (Dold & Marton, 2011, Paragraph 7) that showed neither the herbal supplement St. John's Wort nor Pfizer's antidepressant Zoloft was as effective in treating depression as the placebo effect. By claiming the placebo effect is more powerful than either CAM or conventional treatments the article succeeds in shifting the terms of debate from those circumscribed by the medical journals to an emphasis on the interdependence of body and mind in health. This view is particularly important for women's health as women have been historically subjected to allegations of inventing illnesses that have no physical verifiability (Ehrenreich & English, 2005).

Although this *WH* article on the placebo effect supports it as a valid means of healing, it still references science as the gold standard by which to measure results. For example, the claim that Beecher proved the efficacy of the placebo effect was "scientific fact" uses the word "science" rhetorically to bolster authority for its own claim—namely that the placebo effect is efficacious and clinically significant; however, this conclusion is one that most medical scientists disagree with, according to my research. This is consistent with Beck's (1992) observation about reflexive scientization: in reflexive modernity science is used against itself to promote counter arguments: "Forms of 'alternative' and 'advocacy science' come into being that relate the entire 'hocus-pocus of science' to different principles and different interests—and therefore reach exactly the opposite conclusions" (p. 161). The demystification of the sciences thus results in the loss of universal claims on "truth" that science has historically enjoyed (Beck, 1992). When

women's popular media engage with reflexive scientization they are therefore participating in the popularization of this demystification.

Although this article does challenge the assumptions of medical science, it does not fully explicate the complexity of the placebo effect. For example, it is careful to differentiate between conditions the placebo effect "works" for (cramps) and those it does not (a broken leg), thus providing discrete effectiveness categories that simplifies the complexity of the mind-body connection. For example, in the broken leg scenario, the placebo effect would not "cure" the broken leg but could contribute to quicker healing (Kaptchuk, 1998).

The article also provides a side bar to illustrate things the placebo effect works for, which all happen to be conditions that affect women much more than men. These include irritable bowel syndrome (which affects women more than twice as much as men, 14% versus 6.6% [Wilson, et. al., 2004]), depression (which affects women about twice as much as men [Mayo Clinic Staff, 2013]), migraine (18% of women versus 8% of men [The Migraine Trust, 2012]), and chronic fatigue syndrome (which affects women four times more than men [CFIDS, 2011]). Yet, the gender disparities in the incidence of these diseases is never mentioned in the article. Perhaps the selection of these conditions was due to the fact that they affect women more than men; however, these are diseases that are difficult to diagnose, have little to no effective treatment options, and, because they are women's diseases, may be more closely linked in important ways to structural oppression (the Mayo Clinic makes this assertion in at least part of its description of why

women suffer from depression more than men). By arguing the placebo effect is useful in illnesses specific to women, a link is made connecting women's mental state to physical illness, an assumption which has been historically used to oppress women (Ehrenreich & English, 2005). This article could therefore benefit from a more complex gender-specific analysis of the placebo effect and its history.

In the other article I analyzed that discussed the placebo effect—this one featured in *Prevention*—the editorial perspective was pro-CAM, yet addressed its efficacy within the circumscribed debate of the medical community: either the placebo effect is at play (meaning the treatment is not efficacious) or it's not (meaning the treatment works). The article on acupuncture entitled, "An End to Pain," explores the supposed benefits of acupuncture as well as analyzes the controversy among Western practitioners who see the benefits as *merely* from the placebo effect:

> But for Western doctors and researchers, this explanation does not rise to the level of objective proof. As a result, "there has been an explosion of study on the bio-mechanisms of acupuncture over the last ten years, showing complex, verifiable responses in the brain, nervous system, and connective tissue," says Arya Nielsen, PhD, senior attending acupuncturist in the department of Integrative Medicine at Beth Israel Medical Center in New York City. One recent review named more than 20 scientifically established benefits of acupuncture, from increasing the effects of painkilling endorphins to boosting immune function to releasing anti-

> inflammatories (which reduce swelling and help healing). (Tarkan, 2011, Paragraph 7)

This article does not challenge the medical community's views on testing efficacy, but instead tries to prove that acupuncture is effective beyond the placebo effect using existing scientific standards. Thus, while the article is pro-CAM, it still falls within the debate circumscribed by medical journals: namely, that if a treatment is to be proven effective it must be done through scientifically verifiable routes and that proof of the placebo effect means that a treatment basically has no efficacy. However, the article does suggest, as do some pro-CAM doctors in the medical journals I analyzed, that acupuncture may not be amenable to testing via the RCT because fake acupuncture is difficult to simulate.

This last example is illustrative of much of the coverage in women's popular health media: it is generally pro-CAM and tends to frame the debate on the placebo effect similar to how conventional medicine sees it (i.e. if a treatment does not work outside the context of the placebo effect it is not effective). However, the first article illustrates that occasionally these outlets challenge fundamental assumptions of medical science, such as the value of the placebo effect in contributing to healing. Although the first article failed to adequately explain the gender disparities in the illnesses described and also did not discuss the structural causes of disease, such as women's oppression, these critiques in women's popular health media illustrate that popular media have the potential to provide a starting point for the critique of biomedicine.

Both the *WH* article on the placebo effect as well as one of the *Dr. Oz Show* episodes I analyzed critiqued pharmaceutical companies. It is important to note that these criticisms were not expressed in articles *about* pharmaceutical companies; instead they are discussing different issues, the placebo effect and Dr. Andrew Weil's new book *Spontaneous Happiness* respectively. The fact that these critiques are mentioned in passing suggest that media producers have taken for granted the corruptness of at least one facet of the modern medical institution, as the passage below from *WH* illustrates:

> Yet placebo is still sometimes considered a dirty word. Pharma companies go to expensive lengths to show that their meds outperform inert pills, and drug trials are often dismissed for having 'just a placebo effect.' For a consumer, though, the most fascinating thing about faux treatments (yes, including stuff like Cullen's mint water) is what they reveal about the healing power of the mind. (Dold & Marton, 2011, Paragraph 3)

In this example, the magazine posits consumer interests against those of pharmaceutical companies, situating them in an antagonistic relationship by highlighting how money corrupts the drug production system and disadvantages medical consumers.

On *The Dr. Oz Show*, Weil also comments about the corruptness of pharmaceutical companies. In his discussion of what he perceives to be the problem of the overmedication of Americans with antidepressants, Weil notes:

> This [the number of Americans taking antidepressants] cries out for explanation. Why is one in 10 Americans taking antidepressant medications? Well, two big

> possibilities to consider: the first is that a significant portion of this has been created by the medical pharmaceutical complex, and I think there's no question about that. We have been sold a bill of goods telling us that ordinary stints of sadness are chemical imbalances of the brain that have to be treated by taking drugs. Now, I don't think that's true in many cases, so some fraction of this depression epidemic is manufactured. I don't know what it is maybe a third? If you take that away, it still leaves us with a lot of depression to be explained. ("The Ultimate Happiness Plan," Winfrey, 2011)

Weil voices a critique made by many health scholars who have studied the marketing tactics of pharmaceutical companies and argued that they are attempting to expand disease categories for financial gain[liv]. It is telling that both *WH* and *The Dr. Oz Show* discuss pharmaceutical corporations' corruption in passing[lv], as if the corruptness of pharmaceutical companies is a given—another bit of common sense that needs no further proof. These examples illustrate how the popular media's skepticism of institutional medicine has become so widespread, that it has become almost common sense.

A popular women's magazine such as *Women's Health* and a talk show program such as *The Dr. Oz Show*, thus function discursively to contribute to the social shift occurring within conventional medicine today: from a view of alternative medicine as quackery, to engaging with patient interest in, and demand for, these therapies. Indeed, this language illustrates, "how semiosis figures within processes of change" (Fairclough, 2001, p. 28). The new common sense that articulates pharmaceutical companies to

corruption thus encourages consumer skepticism of pharmaceutical products, thus possibly affecting people's health decisions. The consequences of these decisions reverberate through the medical system both in the increase of capital being spent on CAM, instead of, or in addition to, conventional drugs, as well as may change how people view the reputability of conventional medicine. This is a problem physicians are well aware of and is, to a certain extent, the reason why they do not want to publicize their own research flaws:

> Already feeling that they're fighting to keep patients from turning to alternative medical treatments such as homeopathy, or misdiagnosing themselves on the Internet, or simply neglecting medical treatment altogether, many researchers and physicians aren't eager to provide even more reason to be skeptical of what doctors do—not to mention how public disenchantment with medicine could affect research funding (Freedman, 2010, page 2, Paragraph 18).

The media do not just fault pharmaceutical companies for corruption, their critique extends to conventional doctors. In the next section, I discuss how the media's construction of conventional doctors as cold, disconnected, and impersonal, provides an ideal space from which Oz is able to construct himself (and thus his brand) as the polar opposite: a caring doctor, one who advocates patient empowerment at the same time he educates the audience. I also show how he encourages the audience to engage in reflexivity by teaching them to be both critical of doctors and active participants in maintaining their health. Because he does not take the role of all-knowing practitioner he

makes his position as expert difficult to critique at the same time he enhances his own credibility and promotes his brand.

Patient Criticism and the Construction of Expertise on "The Dr. Oz Show"

As I established in the introduction, experts are necessary in the risk society to construct knowledge, yet are increasingly called into question in the media because of public skepticism of institutional authority (Beck, 1992). This is also true for medical expertise. In one *New York Times* column on how patient-doctor relationships are increasingly strained, Parker-Pope (2008) cites a study conducted by Johns Hopkins and published in the journal *Medicine* that shows one in four patients believe their doctor has exposed them to unnecessary risk. The risks of conventional medicine presented in the media have contributed to this perception:

> The reasons for all this frustration [patients being frustrated with doctors] are complex. Doctors, facing declining reimbursements and higher costs, have only minutes to spend with each patient. News reports about medical errors and drug industry influence have increased patients' distrust. And the rise of direct-to-consumer advertising and medical Web sites have taught patients to research their own medical issues and made them more skeptical and inquisitive. (Parker-Pope, 2008, Paragraph 9)

This quote illustrates Beck's (1992) argument that in late modernity risk is based on a knowledge economy that is dependent upon, yet skeptical of, experts; thus individuals take it upon themselves to research their own medical conditions, gleaning information

from multiple sources and engaging continuously in reflexivity. This quote also highlights the importance of media in influencing public skepticism through stories that cover medical errors and the corruption of modern medicine.

Women's popular health media clearly provide a forum for, as well as contribute to, women's skepticism of doctors. In one *WH* article entitled, "Don't Get Surgery in July," the risk of medical mistakes is posed to readers as exceedingly common, accounting for 98,000 deaths per year. Other feature articles detail the importance of women doing their own research because of doctor misdiagnoses (Moore, 2010). In addition, the *WH* article on the placebo effect points out the importance of the patient-doctor relationship in healing, "A Harvard University study found that the effectiveness of a placebo treatment rose from 44 percent to 62 percent when the doctor treated patients with warmth, attention, and confidence" (Dold & Marton, 2011, Paragraph 11). Discussing the placebo effect in terms of the relationship to the practitioner hints at how important the patient-doctor interaction is to patients' perceptions of healthcare.

Oz, like other doctors (Parker-Pope, 2008), seems to be aware of this public skepticism and makes a good attempt at winning over female viewers by sympathizing with them while simultaneously accepting blame for himself and other doctors not adequately attending to women patients' needs. His attempt to differentiate himself from other doctors has created ire among some of the opponents of CAM that I identified in the medical journals. For example, in one interview, Dr. Paul Offit, chief of infectious diseases at the Children's Hospital of Philadelphia and vaccine advocate (also the author

of one of my "negative" articles from *JAMA*) calls Dr. Oz to task for supporting alternative medicine and featuring alternative practitioners such as Joe Mercola on his program, "'He [Dr. Oz] gives a lot of good advice,' including advice about diet and exercise, Offit says. 'But he mixes that in with a lot of terrible advice'" (Szabo, 2013, Paragraph 80). Similarly, in an April 26, 2011[lvi] episode of *The Dr. Oz Show*, Dr. Steven Novella (a source included in another of my "negative" articles on CAM) appears to defend his view that alternative medicine is not efficacious because it is not based on science. Novella, an academic clinical neurologist at Yale University, argues with Oz that the therapies Oz endorses such as supplements and homeopathy have no efficacy. After his appearance, Novella authored an article about his experience on Science-Based Medicine, a website he created, featuring the views of doctors who believe they need to advance science because they are being overrun by proponents of alternative medicine. Novella notes of his experience, "But proponents of modalities that are not backed by evidence, like Dr. Oz, desperately want to make the debate about something else. So they invent issues that don't exist, such as being afraid" (Novella, 2011, Paragraph 7). These examples illustrate media synergy between medical journals and popular health media. Prestigious doctors who critique CAM engage with Dr. Oz in the mass media and discuss Oz's influence on forums such as Novella's blog, therefore contributing to a robust counter-criticism of the CAM practices Oz endorses. In addition, their critiques bolster Oz's credibility among audience members, thus apparently aligning him more closely with patients' interests. Oz knows this, and even foregrounds his sometimes "outsider" status by noting that he has been attacked by some of his colleagues for pushing

alternative medicine, claiming that he has put his reputation on the line. Therefore, he not only constructs himself in opposition to other doctors, other doctors help to enhance his rogue status by critiquing him across various media platforms.

The above media examples illustrate that the doctors who author the articles in the medical journals I analyzed are not disconnected from the popular media. They engage with it, and make sure their points are also part of the public discourse. Not only are they interviewed in news contexts, they appear on talk television, such as Oz's show, illustrating that they understand the importance of popular media in constructing what counts as an appropriate approach to medicine. When Oz has Novella on the show, he asks him confrontational questions that challenge the assumptions of conventional medicine, ones that perhaps patients want to ask, but given time constraints, or the power dynamic in the patient-doctor relationship, do not. For example, Oz frames the discussion on CAM using statistics that show that many patients do not share their alternative medicine use with their doctors. He states:

> Do you know what I think the big problem is? Do you know why people aren't talking to their doctors? Because they don't think their doctors know anything about it [alternative medicine]. Is that close to on target folks? So if I can give you my take, alternative medicine I think is at the grassroots level. And because of that, nobody owns it. Now that stated, I think we got our homework to do. I think alternative medicine empowers us…and if it works for you then trust me do not

> let anybody take it away from you" ("Controversial Medicine: Alternative Health," Winfrey, 2011).

In this example, Oz articulates the patient's position for them. He also connects CAM with a grassroots movement that assumes a counter-cultural component, while positioning conventional doctors as domineering, by asserting that some conventional doctors may be trying to take CAM away from patients. He thus reinforces the dichotomy between patient and doctor, while also reinforcing his brand as patient advocate. Interestingly, one of the ways the Novella tries to discredit CAM is by using the term, "brand" rhetorically to refer to how alternative medicine has become popular with consumers. He suggests that alternative medicine is "branded" as natural, and thus assumed safe, when it may have negative effects similar to conventional remedies. By using the language of branding, Novella concisely asserts that CAM is a hoax, constructed as superior to conventional medicine through the deceitful practices of marketers.

In this section, I argued that Dr. Oz engages with critiques that have been made by women of conventional medicine in the past, including being written off by doctors as hysterics and feeling as if doctors don't respond to them on a personal level. Through his acknowledgment of these critiques and his self-construction as both understanding and open to other's opinions, including alternative practitioners and audience members, Oz creates a self-brand that connects with the elements women patients tend to seek from CAM and thus becomes a trusted authority figure for women. In the following section, I

elaborate on Oz's brand, and discuss how his endorsement of CAM has contributed to its widespread popularity.

Brand "Oz": Conventional and Alternative Medicine Expert

Oz has the credentials that make him an expert in both conventional and complementary medicine. The star of the show, Dr. Mehmet Oz, is a Harvard and University of Pennsylvania trained cardiac surgeon who, along with his television hosting position, is also vice-chair and professor of surgery at Columbia University and Director of the Cardiovascular Institute and Complementary Medicine Program at New York Presbyterian Hospital. He has had a career not only in medicine, but in the media as well. Prior to the launch of his show in 2009, he was a recurring guest on *The Oprah Winfrey Show,* appearing in 55 episodes as a medical expert. He is also a frequent guest on the talk show circuit and has served as a medical consultant to Discovery Communications. He has even served as medical director for major Hollywood films such as *John Q,* a 2002 film starring Denzel Washington. In addition to his television media presence, Oz has authored seven *New York Times* bestsellers, entitled the "*You*" series that cover topics such as *You: being a smart patient, You: being on a diet, You: being beautiful,* and *You: staying young*. According to his website, he also contributes regular columns to *Time Magazine, AARP, Esquire,* and *O: The Oprah Magazine.* Oz is also the host of a daily talk show on Oprah's Sirius XM radio station. Clearly Oz's media presence is ubiquitous and the media industry recognizes him as influential: along with receiving two Emmy awards for *The Dr. Oz Show*, he has been named *Forbes'* #3 (2010, 2011) most

influential celebrity as well as been named to one of *Time Magazine's* most influential people (2008).

Oz is well positioned both in medical knowledge and in his media know-how to be a trusting figure for television audiences. The way he constructs his persona on television highlights his conventional medical expertise at the same time he forwards a caring, compassionate, doctor—one who aligns more closely with what patients seek in alternative practitioners (Ernst, Resch, & Hill, 1997). In this way he constructs himself as a sort of hybrid of the two—a doctor who has medical expertise and a caring touch. Therefore, Oz's brand is a media-savvy doctor, one who, like his patients, shares an interest in, and appreciation for, CAM.

Thinking of Oz as a "brand," helps to situate his multiple mediated ventures into a coherent framework and foregrounds the shared audience of women consumers that health magazines and his program cater to. Banet-Weiser (2012) defines a brand as, "the intersecting relationship between marketing, a product, and consumers" (p. 4). Oz's brand contributes to the political push for CAM to be accepted within conventional medicine, yet it is worth noting here that his brand also contributes to how CAM is branded. CAM is a bit different from Banet-Weiser's description of brands. She discusses both consumer products such as Coca-Cola as well as certain organizations, like the Mormon Church. Unlike these examples, CAM is not one product or encompassed by any one organization; therefore, it is more akin to how she describes New Age Eastern spirituality: as a movement that has been branded in a particular way and has thus been

articulated to a certain set of meanings. The New Age Eastern spirituality example she uses provides a similar example of how CAM has been branded. For example, in her discussion of yoga (which also falls under the rubric of CAM), Banet-Weisesr discusses how it has been almost completely disarticulated from its spiritual roots in Hinduism, and instead has come to stand in for a somewhat benign, pseudo-spiritual, whitewashed practice of upper-middle class Americans. Similarly, as I discussed in the introduction, CAM is also generally used by upper middle-class consumers, thus it is also associated with a particular form of wellness constructed by privileged consumers.

As a CAM endorser, Oz enhances this meaning at the same time he creates his own brand as closely interrelated with CAM. As both Banet-Weiser (2012) and Ouellette (2012) point out, influential celebrity figures can be important in connecting causes with particular meanings. For example, Ouellette (2012) argues that Sarah Palin's "brand" helped reinvigorate the Republican Party by creating a sense of authenticity and folksiness. Oz similarly provides a strong endorsement for CAM being incorporated into conventional medicine, positioning it as both counter-cultural and empowering. In this way, his brand functions in the interest of advancing CAM in the medical community; but by focusing on CAM as counter-cultural and empowering, he also associates it with an empowerment only open to some middle-class patients[lvii]. Now that I have discussed Oz's brand, I will provide specific illustrations of how he brands himself as a caring, compassionate doctor in opposition to the cold, disconnected medical expert.

In one show that exemplifies how Oz blends his conventional expertise with his image as a caring doctor, cooking star Paula Deen appears as a guest to discuss her struggle to quit smoking. Oz references his expertise as a surgeon to encourage her to quit, “You’re such a role model but the story you’re telling me I hear all the time. I’m a heart surgeon as you know. Did you know that I have never operated on a smoker in my life?” (“Dr. Oz Takes on the Queen of Southern Cooking, Paula Deen, and Paula Deen’s Shocking Health Confession, Winfrey, 2011). When Deen asks him why, he replies, “Because I love them too much. If I operate on a smoker, I’ve given up my own chance to get them to stop. So I tell them when they come to my office that I appreciate their trust, I know I can help them, I know I can get them to live a long time but I wait to do it until they stop” (“Dr. Oz Takes on the Queen of Southern Cooking,” Winfrey, 2011). Oz asserts his affection towards Deen and other guests or audience members in a similar way by saying that he “loves them,” thus his care for people is foregrounded rather than his seeing them as patients only.

Through his self-construction as a caring doctor Oz challenges the traditional norm of the patient-doctor power differential. In his discussion of the dominant ways in which patients and doctors interact, Fairclough (2001) notes, “The dominant way probably still maintains social distance between doctors and patients along with the authority of the doctor over the way interaction proceeds; but there are other ways which are more ‘democratic’, in which doctors play down their authority” (p. 29). This is exactly what Dr. Oz does on his show. He frequently plays up the expertise of other doctors (both conventional and alternative), and sometimes his audience, and encourages

patients to take an active-role in challenging their doctors' recommendations, including his own. As I will show in the following examples, Oz's brand is counter-hegemonic to the dominant ways in which patients and doctors have typically interacted. Oz's show in some ways presents a more "democratic" sort of relationship between doctor and patient, resulting in the idealization of Oz and leading to difficulty in countering the sometimes patriarchal and patronizing elements of his show[lviii].

Patient Empowerment and Audience Education in Reflexivity

When Oz straddles the line between expert and patient advocate, he engages with and even intensifies public sentiment that has expressed dissatisfaction with conventional care. Engaging the topic on the show illustrates a step away from the model of doctor as unquestionable expert and presents doctors as real people with biases and judgments, just like anyone else, thus Oz participates to a certain extent in the demystification of the profession. In his discussion of Beck's and Gidden's view of public distrust of experts, Irwin (1994) notes:

> Where once there was certainty there is now radical doubt. Faith in expertise has given way to a more reflexive process of criticism and ontological anxiety. Citizens are aware of the choices which exist—above all, about how to live—and that there is no single answer to life's challenges. (p. 174)

Similarly, Oz counters the superiority of scientific knowledge claims as the only truth, and doctors as the arbiters of it, by, for example, carefully counterbalancing his medical advice to the audience with a message of empowerment designed to encourage women to

question their doctors and be proactive in their healthcare. In one 2011 interview in *Prevention,* Oz states that patient empowerment is one of the main goals of his show:

> The *Prevention* readers are the eyes and ears for us. If they can understand that they have the responsibility to be that vanguard, to be the patriotic person--because it is patriotic to be the one who challenges their doctor by requesting a second opinion, asking to see their records, asking about alternative medicine--they're forcing their doctors to learn something they didn't know before, which means every other patient they see after them will benefit because they were willing to be first. (Caploe, 2011, Paragraph 16)

It is telling that Oz refers to patients getting a second opinion as "patriotic" suggesting his show becomes political (while reinforcing his counter-hegemonic brand) by participating in the struggle over the acceptability of CAM within the medical community. In this example, Oz is on the audience's side and provides validation for, as well as promotes, alternative therapies.

Suggesting that patients can force doctors into acknowledging the value of alternative medicine also challenges the traditional patient-doctor relationship. Yet Oz straddles a fine line between encouraging patient empowerment and asserting that patients have a *responsibility* to question their doctors. By putting the responsibility on finding good health care on patients, Oz is holding them accountable for the quality of care (or lack thereof) that they receive, as well as advancing his own agenda through audience members, hoping their doctors will respond. This example also illustrates a

neoliberal slant in the emphasis it puts on personal responsibility, which is also one of the central tenets of contemporary health discourse (Dubrwiny, 2013).

Yet, occasionally Oz also allows his audience to be in the position of "expert." For example, women on the show are sometimes featured in small segments to share their tips on topics like how to add lasting weight loss techniques to daily life. In one segment featuring several female viewers sharing major weight loss achievements, Oz asks the women to give the audience their tips for losing weight and keeping it off. The women share recipes for marinades, propose alternatives to peanut butter, and offer various ways to prepare cottage cheese in order to keep unhealthy food cravings in check. Oz closes the segment by praising the audience's ingenuity, "That's what I love about our audience: you guys figure out such smart and simple ways from very simple ones, some cutting edge ones, but they're all there" (Winfrey, 2011). For the most part, this type of show that allows audience members a position of expertise is relatively rare; but it does allow for some voice among female audience members.

Calling on audience members as sources of expertise is one of the reasons feminist media scholars such as Shattuc (1999) and Mellencamp (1999) have asserted that talk shows are so popular among women and potentially valuable for women. In her discussion of television talk shows, Mellencamp notes, "And while rational thought—in the form of the outside expert or analyst speaking from the distanced third person of scholarship (usually hawking a new book around which the topic is arranged)—is included, first-person accounts, stagings of affect, count more than intellect or third-

person analyses. The hierarchy between mind and body, between thought and feeling, is dissolved, with the latter, traditionally aligned with women, emerging as most valued" (Mellencamp,1990, p.214). While *The Dr. Oz Show* does not usually privilege audience members' views over experts, he does ask audience members to be active in maintaining and improving their health, and frequently validates their subjective experiences of health and medicine. On Oz's show strict reliance on expertise is never sufficient for the kind of health empowerment that Oz endorses on his program. Thus, he not only allows his audience to be experts at times, he also educates them about how to be reflexive.

As I discussed in chapter three, in the risk society, individualization, or the necessity to make one's own choices in late modernity, seems to be necessitated by the multiplicity of risks and competing knowledge claims that characterizes the risk society; Oz participates in teaching his audience to be reflexive as a means of dealing with the multiple profusion of risks. Therefore, to a certain degree, he exercises what Foucault terms, "pastoral power." This form of power is not repressive, but rather productive. It requires that the expert know intimately the subject in question and then help guide them in making the correct decisions (Nettleton, 1997). Oz does this by encouraging self-reliance while at the same time providing instructions for how to make the correct health decisions. For example, in one episode that focuses on detecting health scams, Oz asserts that supplements may be contaminated with heavy metals or other additives that can harm consumers' health. He tries to reconcile his frequent recommendations to take supplements with this danger by directing audience members to a pay website, consumerlab.com, that does independent testing of different companies' supplements and

rates them for purity. He then offers his audience a free 24-hour access passcode to the site so that they know which brands to purchase and their level of purity.

In this episode, Oz shows women that they should be skeptical about which alternative therapies they choose as well as how to be skeptical. For example, he details a list of supplements that he believes consumers should be wary of and describes how some companies, following his endorsement of African mango, have used his image to promote their supplements. Oz undertakes a sting operation by creating his own fake product, complete with a website, to see if he can dupe consumers into believing that it's real. The show then features one woman who was fooled by the site. When he asks her how she felt when she found out that the site and product was a sham, her response illustrates the influence Oz has on some viewers: "I felt duped. I thought I was getting a miracle weight loss product by you, so it was my fault. I run out and buy everything you say" ("The Top Seven Health Scams: Are You Being Duped Now?," Winfrey, 2011). After this interaction Oz tries to downplay his authority by encouraging the audience to be critical, "I want you to hear me clearly…when I see you buying something that my picture is on it concerns me; it's not that I don't want you to trust me. I want you to trust me, but the truth is in you, it's in all of us. The wisdom and the insight to be able to make decisions that govern our health has to always be in us" ("The Top Seven Health Scams," Winfrey, 2011). Yet, it's not surprising that the woman would believe Oz given his influence. This episode illustrates how Oz tries to balance women's abilities to trust the experts and their own need to trust themselves as a means to discern the best decisions for their own, and often their families' health[lix]. This example highlights the tenuous line women must

negotiate in late modernity between trust and skepticism in a health market that is flooded with contradictory evidence and thus makes decision-making about health increasingly difficult, making the reliance on a trusted expert even more valuable for consumers.

In this supplement scam episode, Oz participates in educating his audience about how not to be duped by online fraud. In order to teach the audience how to determine "real" from "fake" products, Oz features an online scam expert. Similar to the medical journals, the show thus frames women as an audience that must be educated about how to negotiate healthcare decisions; in Foucauldian terms, they become subjects in need of governance. However, unlike the coverage in the medical journals, Oz not only assumes the public can make their own decisions, he demands they do. In Oz's program, women can rely on experts—including Oz himself—but only so much.

Women being empowered to take control of their health is of course, important, but there are critics of the all-encompassing discourse of health empowerment (e.g. Dubriwny, 2013, Gastaldo, 1997 and Petersen, 1997) who describe health management as a form of disciplining the self. In this sense health empowerment is restrictive because it places a sense of responsibility on individuals to continually monitor their health, even in the absence of any clear illness. Although Oz's imperative that patients take responsibility may be burdensome at times, there are moments on his show that illuminate social and structural issues that affect health, such as the lack of insurance for all Americans and gender discrimination in healthcare. These critiques thus take his show out of the context of framing health as strictly individualistic. In episodes that discuss

how the U.S. medical insurance system is unjust, or how male doctors discriminate against female patients, Oz is able to highlight some important structural influences on health.

In this section, I have argued that Dr. Oz participates in reflexive critique of institutional medicine and conventional doctors by constructing himself, and thus his brand, as self-reflexive and counter-cultural. I have also argued that his taking into account other expert sources including female audience members, allows for women to have a voice. Finally, I have shown that his show serves as a vehicle for patient education, designed to teach audience members how to be reflexive, thus illustrating how he participates in administering pastoral power. In the following section, I analyze one episode in which Dr. Oz addresses social problems in medicine in his discussion of gender discrimination in healthcare in the context of chronic pain. In this episode, he not only discusses women's chronic pain in the context of gender discrimination, but continuously shores up his own credibility by critiquing doctors and providing an alternative view to their patronizing assumptions about female patients.

Chronic Pain: A Woman's Problem

The selection of chronic pain as a focus of a *Dr. Oz Show* episode is important for women's health: 80-90% of sufferers of fibromyalgia, or chronic pain, are women (CFIDS, 2011), and some doctors question whether this illness exists at all (Berenson, 2008). In his exploration of the topic, Oz begins the segment right away by positioning himself in opposition to other doctors: "There are a lot of doctors who are going to be

really angry about what I'm talking about today… 116 million of you suffer from chronic pain and I'm ashamed to say that we doctors haven't been taking your pain seriously enough" ("Why Your Doctor Thinks You're Crazy!: Is Your Chronic Pain a Disease," Winfrey, 2011). At the same time he positions himself in opposition to doctors whom he will make angry, he also accepts blame by saying that he is "ashamed" that "we doctors" haven't been taking women's chronic pain seriously enough.

Oz foregrounds gender at the beginning of the episode by featuring three women who have been suffering from chronic pain for years, all of them with stories about how their doctors either did not believe that they were suffering from pain or told them that their problems were psychological. After the video montage featuring the women, Oz interviews Sheila, a black woman who appears to be in her 40s or 50s, asking her how it made her feel that her doctors thought her problem was mental rather than physical. Sheila says that it made her angry; as Oz holds her hand, she claims that because the doctor could not figure out the problem he was trying to make it into something mental. Oz agrees with her, "that's a great insight; sometimes we can't figure it out so we put the guilt back on you" ("Why Your Doctor Thinks You're Crazy!," Winfrey, 2011). Here, Oz listens and responds to, Sheila, validating her subjective experience of pain as real and situating doctors as at fault.

Another woman Oz profiles, Hillary, claims that her chronic pain, which she has been experiencing since sixth grade, has kept her from being the kind of mother she hopes to be. She says that she has seen ten neurologists and that they just want to give her

drugs, “I’ve never really been touched [the sentiment seems to refer to the doctors just wanting to medicate her rather than listen to her closely],” (“Why Your Doctor Thinks You’re Crazy!,” Winfrey, 2011). Distancing himself from her cold practitioners, Oz holds her hand thus providing the human “touch” that she was seeking from her doctors. His comment following her statement emphasizes this role, “I was taught by a teacher very early on that just looking at someone in their eyes and knowing that they’re [doctor and patient] together for each other makes a big difference” (“Why Your Doctor Thinks You’re Crazy!,” Winfrey, 2011). In these examples, Oz again carefully constructs himself as a caring, more humane doctor and also as more interested in patients than the critiques of doctors being voiced in popular media.

Along with featuring the women in the videos, on this show all of Oz’s audience members are also chronic pain sufferers and he interviews some of them as well. One white woman from the audience named Susan claimed that when suffering chronic pain after leg surgery she was told by her doctor to go home and “have more sex” with her husband (“Why Your Doctor Thinks You’re Crazy!,” Winfrey, 2011). Oz is appalled, and picks Susan’s example of blatant gender discrimination in diagnosis to open up the topic of gender discrimination in medical care. Before convening a panel of experts on chronic pain, Oz talks to another woman in the audience who similarly describes being prescribed medication that she did not want to take and when she had problematic side effects was told by her doctor that she would get used to them. When Oz asks her how that made her feel, she says, “dismissed,” (“Why Your Doctor Thinks You’re Crazy!,” Winfrey, 2011). Oz affirms her sentiment and asks his audience how many of them felt dismissed by their

caregivers; most of the audience raises their hands. When Oz incorporates his audience through both interviews and as a collective group that has experienced discrimination at the hands of their doctors, he engages in a sort of consciousness-raising moment, reminiscent of the practices engaged by women's health activists in the 1970s, for example in the Boston Women's Health Collective (Morgen, 2002). Thus, his show appears to be somewhat feminist at brief junctures.

Before he delves into the reasons why doctors think chronic pain sufferers are "crazy," Oz begins with a bold challenge to many doctors:

> I'm going to let the audience in on a little secret here that no one's going to admit until now… and it's going to shock a lot of folks, and it's going to piss a lot of doctors off, so I'm just going to get it out there, cause when I hear these stories, it frustrates me. But it's hard to get proper treatment because in my opinion doctors do think you're crazy; they think the pain is all in your head ("Why Your Doctor Thinks You're Crazy!," Winfrey, 2011).

In this example, his position as a doctor allows him insight into doctor "secrets," such as their apparent suspicion that chronic pain sufferers are crazy. Thus, he participates in the active critique of the profession, encouraging women audience members to do the same.

Some doctors appear to be aware that patients who suffer from chronic pain generally have a negative perception of their doctors and tend to seek out CAM therapies as a result of this dissatisfaction. For example, in one recent *NEJM* article, Pizzo (2012) notes, "Physicians' referral of patients to other health care professionals, including

nurses, chiropractors, and practitioners of complementary medicine, and patients' willingness to seek such care, can be influenced by bias, unclear data, and the availability of care. Sadly, many people with chronic pain see physicians as poor listeners" (Paragraph 2). Oz's acknowledgment of this problem and his apology for himself and other doctors makes him an idealistic version of what doctors should be: more caring, understanding, and accepting of patient's subjective experiences at the same time he reinforces his brand of rogue compassionate doctor. Similar to how Sarah Palin constructed herself against elite politicians and the media, (Oullette, 2012) Oz similarly constructs himself as a rogue. He is more understanding than doctors, real, and not disconnected from his patients' experiences.

Among the four reasons Oz provides for why other doctors think that chronic pain sufferers are crazy is that they can't see pain, and therefore believe that it is not present. To further explain this point Oz features a guest who is a member of the committee at the Institute of Medicine (IOM) that investigates chronic pain, Dr. Shawn Mackey. Mackey claims changing the way that doctors conceptualize pain—that it is in fact "real" and can permanently change your nervous system—is a "cultural revolution" ("Why Your Doctor Thinks You're Crazy!," Winfrey, 2011). The use of the word "revolution," associates new research on pain with radically changing the medical establishment's prior views; in addition, because the show references gender, "revolution" also implicitly refers to the women's revolution, or at the very least, a women's revolution in receiving adequate care for chronic pain. Finally, by using the word "cultural," Mackey situates medicine squarely within culture, not outside it, as science and medicine have historically imagined

themselves, and as the doctors and scientists in the medical journals I analyzed tended to discuss it. The use of the words “cultural” and “revolution” creates an oppositional discourse to how chronic pain has traditionally been described in the medical community. This segment also shows that those within the medical profession, such as Oz and the other doctors on the episode he interviews, are participating in shifting medical culture from doctor-centered to more patient-involved.

Among the other three reasons why, according to Oz, doctors think chronic pain sufferers are crazy, are that they do not have much pain management training and that they think patients are trying to abuse prescription medications. Finally, Oz presents his fourth reason, which he claims is the most “shocking” reason your doctor thinks you’re crazy: pain sufferers are mostly women. This statement *is* shocking in the context of mass media, where gender discrimination in the context of medical attention has received scant attention. After he reveals this reason the audience gasps and Oz asks his expert on women’s health to explain why that is the case. Unfortunately, the female physician on the panel, Dr. Donnica Moore, does not provide an institutional explanation for why gender discrimination in medical care happens and instead provides a personal example about when she was seeking help for chronic pain. Moore explains that she went to see top male doctors in the country and although she herself was a doctor, they spoke only to her husband who was with her, telling him that she was suffering from postpartum depression. Moore then describes seeing a female doctor who was six months pregnant herself who quickly confirmed Moore’s pain as “real” with a blood test and an MRI. Unfortunately, not only does Moore’s example fail to highlight structural biases in the

medical profession, she also falls back on accepted screening methods within the medical community that are able to "prove" something is wrong. Although these diagnostic techniques may provide insight into identifying a potential illness, leaving her discussion there makes it seem as if tests that are inconclusive or do not show a visible image on the screen, invalidate those patient's experiences and therefore undermines the argument that pain that is not visible may still be real. In addition, by discussing her interaction with a female practitioner who immediately validated her pain, she is forwarding a gender essentialist view that suggests that only a woman would be able to correctly diagnose her problem.

Oz doesn't offer much commentary on the topic himself, likely because he is a male doctor who is asking female patients and audience members to trust him; but he does concede that gender discrimination in diagnosis is "shocking." Oz finishes the segment by describing how chronic pain can now be considered a "disease" and offers the audience questions they can ask their doctor about chronic pain, "If someone's telling you to have more sex, or you're depressed…No, I mean it's tragic, we laugh about it, but it's tragic, or they think it's all in your head, those are telltale signs. You don't have to ask those four questions—just keep moving" ("Why Your Doctor Thinks You're Crazy!," Winfrey, 2011). Similar to the previous episodes I analyzed, Oz's combination of rogue compassionate doctor and medical expert allow him the authority to gently guide women's health information seeking behaviors, legitimate women's subjective experiences of health, and also open up a space to honor their experience as real. By including it as a problem on the show, Oz makes a statement about the differential

treatment of female patients via their experience with chronic diseases that primarily affect women. In addition, by providing a forum for women's health both by addressing women's health issues and featuring cross-promotional segments with the women's magazines I analyzed, Oz enhances his marketability to his audience.

The examples that I have discussed in this chapter illustrate that women's popular health media at times do extend beyond a focus on individualism to point out social issues in healthcare as well as actively participate in the critique of medicine. I am not arguing that these narratives totally challenge the landscape of individually focused healthcare; in fact, much of what I am arguing throughout this dissertation is that women are expected to participate in a great deal of individual labor in order to be educated health consumers. However, the critique of doctors, pharmaceutical companies, and structural discrimination in healthcare articulated by the mass media reflects, and contributes to, a level of popular awareness that points to a source of illness located other than at the level of the individual and this public awareness is a step in the right direction for changing medical care for women.

Conclusion

In this chapter, I have argued that women's popular health media provide a forum for the expression of reflexive critique and therefore have the potential to help instigate social change in medicine. I have discussed how the placebo effect is dealt with more complexly in women's magazines than in medical journals and how *The Dr. Oz Show* provides a platform for women to express their experiences of gender discrimination in

healthcare. I have also shown that these discussions could be improved, for example in the acknowledgment of women-dominated diseases in *Women's Health* and more fully exploring the reason for gender discrimination in healthcare on *The Dr. Oz Show*. I have also shown that Oz constructs himself as a sympathetic figure to female audiences by engaging reflexively with critiques of conventional doctors made by the public and serves as a sort of mediator between patients and doctors. In this way, he sets a standard for what patients should expect from doctors, while enhancing his brand and expanding the market for women's popular health media. Finally, I have shown a specific example of how the representation of risks in popular media provide insight into the shifting relationship between the general public and experts in late modernity[lx]. The examples I analyzed illustrates how popular media can shape the contours of medicine by calling into question everything from the patient doctor interaction to scientific medicine itself.

Chapter Five: Conclusion

On June 18, 2013, my Google alert that had been set up for a few years to provide me news on CAM, pulled stories from CNN.com, *USA Today*, and NBCNews.com featuring opinions on CAM by doctor Paul Offit, whom I mentioned in chapter four and who has authored a new book entitled, "Do you believe in magic? The sense and nonsense of alternative medicine" (2013). One of his claims is that CAM (particularly the supplement industry) is a sometimes exploitative business. Because supplements do not need FDA approval, he argues consumers are being duped and at times subjected to dangerous side effects from these treatments.

While Offit makes an argument typical of the critics of CAM that I surveyed in the medical journals, he does make one important point: CAM is not necessarily more efficacious or better than conventional medicine. I thought it pertinent to visit this point before I conclude because I am not arguing for CAM's superiority to conventional medicine. In fact, in my own use of health care services I admit I am somewhat more skeptical of CAM than of conventional medicine. However, I am arguing that CAM can contribute to conventional medicine in two ways: 1) it can provide alternative ways of understanding health as holistic by fully exploring the mind-body connection, and 2) it can help broaden medical knowledge through the use of alternative methodologies to test CAM therapies. This does not mean disavowing the value of scientifically based medicine; it merely involves displacing science and the scientific method as the sole arbiter of "truth." For example, as I have argued throughout, sometimes the results

science produces change months or years later when a different study is conducted using different methods or asking different questions. Therefore, it is important that scientific results are also scrutinized and not accepted as "fact" until they have been tested through time and experience. It's important to keep in mind as Ioannidis points out, "'Science is a noble endeavor, but it's also a low-yield endeavor'" (Freedman, 2010, page 2, Paragraph 20). Therefore, science also deserves to be scrutinized to the same extent as CAM.

CAM as a Part of Conventional Medicine

Throughout this dissertation, I have argued that incorporating CAM into mainstream medicine challenges medical-scientific methodologies. I have also argued that CAM has historically been more friendly to, and accepting of, women than conventional medicine has, both in valuing their subjective experiences of their bodies as well as allowing them to practice alternative medicine. However, critics argue that CAM may be understood as more disciplinary than conventional medicine as it focuses on holism and total wellness, thus seemingly demanding constant self-surveillance and discipline.

Critics of the discourse of health empowerment (e.g. Gastaldo,1997 and Petersen, 1997), use a Foucauldian lens to describe health management as an all-encompassing form of disciplining the self. In this sense health empowerment is limiting and restrictive because it places a sense of responsibility on individuals to continually monitor their health, even in the absence of any clear disease. It could be argued that the paradigm of holistic health and CAM may place more pressure on individuals to maintain and optimize health at all times. Similarly, Dubrwiny (2013) critiques the ethos of self-

empowerment as it is currently deployed in health discourse. These authors show that a critique of individualism and self-empowerment in CAM discourses is necessary. For example, as I pointed out in chapter three, individualism is one of the negative ideals that CAM is associated with in women's popular health media. Yet, I also illustrated in chapter four that this discourse is not monolithic.

Although Gastaldo's (1997) and Petersen's (1997) critiques offer insight into the context of how alternative medicine may be (and sometimes is) practiced in a neoliberal society, for example, it may be used to emphasize individual behaviors such as diet and exercise as opposed to finding structural factors for illness. I argue that it is not health empowerment or holism per se that is disciplinary; rather it is the current organization of neoliberal American society which emphasizes individualism and personal success that provides the context within which holistic health can be read as disciplinary. Neoliberalism also provides a social context for those who produce information about CAM and may result in advice by those practitioners that reflects those values. Yet, like religion (Hall, 1989), CAM is not inherently repressive—it becomes repressive only when it is articulated to self-empowerment or individualism in a particular way: for example, by suggesting, as some of the media I analyze do, that one has a great deal of control over one's health through making healthy lifestyle choices.

But the articulation between CAM and individualism is not static. As Grossberg (1992) points out, "Articulation is the construction of one set of relations out of another; it often involves delinking or disarticulating connections in order to link or rearticulate

others…Articulation is both the practice of history and its critical reconstruction, displacement and renewal" (p. 54). What Grossberg points to in this quote, is that articulating ideas together, such as mastery over health and CAM, may be disarticulated and re-articulated into a formation that may be positive for women's health (because those associations are already there, as I have shown). One example might be articulating CAM to a collective women's movement that questions gender oppression in institutional medicine and interrogates social and structural causes of illness.

The media continue to perpetuate neoliberal ideas about choice and empowerment for women and this will likely not completely change any time soon (Vavrus, 2007). Similar to how Vavrus (2007) discusses stories in the news media that covered mothers opting out of the workforce to stay home with children, the popular press's coverage of CAM gives the same patriarchal neoliberal treatment. However, CAM is at times dealt with more complexly in women's popular health media; for example, by exploring the placebo effect in ways that challenge the methodological assumptions of scientific medicine, or by discussing gender oppression in medicine. This coverage does not go far enough however. By obscuring the historical oppression of women by the medical profession, gender discrimination in healthcare becomes a "shocking" topic on the *Dr. Oz Show* rather than being framed as an extension of an ideology that has permeated conventional medicine for hundreds of years. Yet, the media consistently participate in the active critique of conventional medicine as an institution, thus showing how their coverage at the very least broaches the topic of changes that need to be made within the system.

Reflexivity and Social Change

I have argued that critiques of medicine voiced in the popular media are illustrative of Beck's concept of reflexivity, and that the media can be used to provide influential platforms for social change within medical institutions. However, critics who analyze the "new public health" (which is marked by an increasing skepticism of medical institutions and community organizing around green and environmentally friendly causes), argue these trends support public health initiatives and serve a disciplinary function that implies citizenship responsibilities ultimately serving as a means for exclusion (Petersen, 1997, p. 204). For example, Petersen argues that green movements tend to be organized by middle-class citizens, thus a lack of participation in such movements may lead to judgment of those who do not participate in such activities.

Although I agree that these imperatives may serve a regulatory function in some cases (by, for example, requiring active participation in interrogating the current healthcare structure), this thesis does not fully address the possibility of positive change that such organizing may provide for health justice. Undoubtedly power is operating on multiple levels—through the government, corporations, non-profits and varying experts—yet power constituted through social organizing around a communal goal cannot simply be written off as an example of a technique of power in action. For the purposes of action, it seems counterproductive to juxtapose state rationalities against the will of individuals. Certainly the desires of the state and its individual citizens are inextricably linked, and analyzing the power dynamics inherent in that relationship is a

valuable goal for analyzing how power operates; but because the goal of this project is to understand how progressive action may be incited through popular media, it remains imperative for me as a feminist health communication researcher to focus on how to understand how to act within the social constraints of society. Yet I do retain a reflexive perspective, acknowledging for example, how reflexivity is used negatively to incorporate sexist discourses into movements such as CAM that are often framed by the media as "progressive," thus masking the patriarchal ideologies that inform how that issue is covered.

In addition, it is important to remember that how the media discursively construct health has consequences not just for individual health actions but for policy outcomes. For example, women's health was a central issue in the 2012 presidential race. President Obama's Affordable Care Act (ACA) or "Obamacare," was a central point of contention between Democrats and Republicans—most notably in the realm of women's health due to its provision that health insurance companies include free contraception for women. This provision has been challenged in states such as Colorado, where Hobby Lobby has refused to offer free contraception for employees, apparently because of the religious beliefs of its founder, David Green (N.A., 2013). In this divisive political climate, the battle being waged over women's health is symptomatic of larger cultural schisms about healthcare and individual rights; this discourse is central to understanding and constructing meaningful arguments that can help assist health policies that are good for women. For example, in her discussion of how women's health activism has been coopted by a neoliberal ethos, Dubriwny argues that the biomedicalization critique that

was present in the women's health movement of the 1960s and 1970s has been subsumed by an emphasis on choice in healthcare options. She argues that many women's health organizations such as the Komen Foundation can no longer be considered "feminist" due to their entanglement with the medical industry. Dubriwny (2013) notes, "The absence of an overtly critical perspective of some professional women's health organizations is a significant part of the new health care landscape that promotes postfeminist, neoliberal messages about women's health" (p. 148). The problems Dubrwiny identifies with the current healthcare environment certainly hold true; however, I also argue that critique of the medical industry is present in women's popular media, and thus represents an example of how resistances to those discourses are influencing the changing healthcare landscape.

For example, as I have described throughout this dissertation CAM is making major inroads in becoming legitimatized within institutional medicine. This is a development that would have been surprising to consider a mere 50 years ago. Along with the creation of the NCCAM in 1998, the ACA also has a provision included that will likely result in more insurance companies covering alternative medicine. Clause, 2706, authored by CAM advocate, Senator Tom Harkin (D-Iowa), "requires that insurance companies 'shall not discriminate' against any health provider with a state recognized license. That means a licensed chiropractor treating a patient for back pain, for instance, must be reimbursed the same as medical doctors" (Rao, 2013). To me, this development shows that while change is slow, it can happen, providing a specific example of how

reflexivity at multiple levels—media, government, and medicine—may incite change around an issue such as health and healing.

Can "risk" be productively deployed in discussions of health?

As I have just discussed, the discursive use of risk may be positive in that it can bring about reflexivity. However, I have also detailed the negative ways in which risk is deployed in discourse in medical journals and the media. So how should "risk" be used in media discussions of health? Is there an appropriate way in which to use the term as an organizing concept? I ask this question because it is almost impossible to talk about health without at some level, addressing risk. I believe the answer is that there is a place for the term to be used, but its discursive construction must be used in ways that discuss risks more contextually, without the certainty (or conversely, the complete unpredictability) with which it is currently discussed in the media (which often do not reflect the studies cited). Because risk is not ideologically neutral, and works to advance certain views of health over others—for example by conflating women's health with their physical appearance—new ways of imagining health can thereby change how risk is deployed in discussions of health; as Fairclough notes, discourse can be an important part of changing the social agenda (2001). Therefore, risk may be discussed in other ways, for example, to highlight the incredibly complex etiology of diseases by providing more nuanced coverage of health studies that concretize the difficulty of generalizing risk across populations. However, given the problems with validity of medical research itself, scientists and medical researchers must also acknowledge their biases and welcome

public deliberation about their work. Providing for a more complex discursive construction of risk in the media may provide more available narratives from which to understand health and illness, a task that will be important for women's health. As Dubriwny (2013) argues, "Our understandings of ourselves and our lives are developed in concert with the narratives that populate public discourse" (p. 176). Therefore, as she suggests, new narratives about health can lead to the improvement of women's health.

Health in the Media and Suggestions for Future Research

Health stories will continue to permeate the media. Indeed they proliferate. Many news organizations such as CNN and *The New York Times* use news categories exclusively dedicated to health, and this is not necessarily a problem. The public has a right to understand and assess health research and new findings, but often this task, even for an educated public, requires quite a bit of outside research to locate, read, and make sense of the various studies' findings in the journals where they appear. Even when one goes right to the source, the picture may not be complete as the journals are not immune to ideological bias, and, in some cases, financial influence (Freedman, 2010 and Fugh-Berman, 2010).

Yet there is hope. My goal is not just to critique the ideological biases in medical journals and popular media, but to provide suggestions for ways in which these biases may be challenged. There is at least some progress on this front. One website, HealthNewsReview.org, founded by former journalist and journalism professor at the University of Minnesota, Gary Schwitzer (sp), provides independent reviews of health

news stories, asking questions such as, “how strong is the evidence?,” “is this condition exaggerated?,” and “do they have a conflict of interest,” (Health News Review, 2013) among others. Of course, the site is not able to review all the health news stories, but it does a good job of guiding users through questions to ask themselves when they read medical stories and provides examples of good and bad reporting on health.

Schwitzer’s website illustrates that some working in journalism and medicine understand the problem of communicating health information in the media; yet how ideology functions in media discourses still needs to be addressed. After all, their stories are not generated from a vacuum: “rather than blaming the media for distorted, alarmist, and unnecessarily convoluted reporting, a sociological view of media discourse on risk suggests that any contradictions, alarm, and complexity in news accounts reflect by and large what journalists hear from various claims-makers, stakeholders, and other expert news sources,” (Stallings 1990, 91). It is therefore essential to interrogate discourse in the medical profession as well to uncover the wider context, ideological assumptions, and ways of viewing health and women that are operating in the social world. This is important because not only is medical information often misrepresented in the media, it is presented in a way that connects patriarchal assumptions about women to health; this has material consequences for women’s lives from the way they view health to how they interact and are treated in healthcare encounters. As Dubriwny (2013) points out, “If public discourse about women’s health is taken for granted, we miss our opportunity to ask questions about what meanings are being made for women’s health and what material consequences those meanings might have” (p. 4).

Future critical media research into the use of risk in health discourses should be investigated in the context of new media. In addition, conversations generated by women on health, for example, on health blogs, or in how they interact with health media, will be helpful to providing insight into how women interact with this media and how their beliefs and practices shape, and are shaped by, these media. In addition, further research is needed on how medical doctors interact with medial information in the media and how they work with patients who have beliefs about health generated partially from media stories or from their own research using online health resources. Ultimately, the task at hand is for critical health communication scholars to continuously engage with reflexivity (both self and social) in order to illuminate paths of resistance, achieving small steps for the improvement of women's health.

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[i] Stories covering the topic were featured in prominent media outlets such as *Time* and *New York* magazines.
[ii] Dimas was supposedly the good thief crucified next to Jesus who repented for his sins before he died.
[iii] I explain this more in-depth in the next chapter.
[iv] They specify Pilates and Rolfing Structural Integration.
[v] Breathing exercises and guided imagery are specified.
[vi] In other places Beck (2003) uses late modernity in the same way as "second modernity."
[vii] While the influence of family obligations was not as important in American life as in the European context, individuals were still expected to adhere to certain familial and social norms such as not marrying outside one's religion or race. This changed substantially following the countercultural movements of the 1960s and 70s.
[viii] I provide critiques of this liberation aspect of individualization later in the chapter.
[ix] Rose (2007) refers to patient advocacy using a term he calls biological citizenship, in which people come together over a shared disease or injury to lobby for medical research or governmental compensation. This concept is useful for thinking about organizing as a citizenship practice. However, I am interested in teasing out how criticism of medical institutions is articulated in the media and what the outcomes of those moments are, rather than identifying what sorts of citizenship practices they define.
[x] Beck usually references reflexive modernity as if it is a tendency of late modernity.
[xi] Beck is alluding here to the loss of metanarratives an example would be the postmodern turn in academia.

[xii] The middle class point is my assertion, not Beck's.
[xiii] See Entwistle and Sheldon (1999).
[xiv] I am not arguing that modern medicine is "bad" or necessarily "repressive," but as an institution it has participated in the oppression of women. Therefore, it is important that medicine be critically analyzed so that it may be improved.
[xv] Conventional usage of "articulated," not Stuart Hall's term.
[xvi] My study did not find significant differences in race, although according to the NCCAM, by prevalence Native Americans use CAM the most, followed by Whites, and Asians.
[xvii] This refers to how women subscribe rigorously to risk mediation during pregnancy, such as abstaining from eating certain foods and drinking alcohol, etc.
[xviii] When I use the term "health context," I refer to how theory is discussed in relation to women's health.
[xix] Dubriwny (2013) makes a similar assertion.
[xx] See Petersen and Bunton's (Eds.), (1997) *Foucault, Health and Medicine*.
[xxi] Their approach also encompasses part of Dubriwny's (2013) "intersectional" approach to women's health, or, "focusing on social structures, understanding power as relational, and emerging from the perspective of individuals outside the dominant group" (p. 170).
[xxii] I use late modernity instead of postmodernity because I want to retain a strong sense of the inequities in access to health care and information.
[xxiii] Hence the term CAM: complementary indicates as a supplement to conventional care, while alternative indicates foregoing conventional care in favor of other methods.
[xxiv] I describe the history of women's subordination to the medical community in the introduction as well as in chapter three.
[xxv] See Sampson, W. (2005), Betancourt, J. (2004), and Straus, S. (2002), Abbott, A. (2005).

[xxvi] Indeed, there is a slippage between healthful eating and exercise as falling under the purview of *both* conventional and alternative medicine. I will discuss this further in chapter three.

[xxvii] According to Eugene Garfield, who created the term in 1955 with Irving H. Sher. The journals I chose deal with general medicine rather than specialty topics such as immunology or cancer.

[xxviii] I also searched the term "quackery" (which was what alternative medicine used to be called) for each journal, which returned a number of results. These perspectives on alternative medicine align with the historical construction of CAM in the medical community that I discuss in the next section.

[xxix] These are termed "Perspective," in the NEJM. There is an editorial section there, but there is no editorial coverage on CAM, though the "Perspective" is similar in nature.

[xxx] These include news stories that have a noticeable slant.

[xxxi] I determined articles to be positive if they wholeheartedly accepted the acceptance of CAM into conventional medicine, Negative if they included a majority of strong criticisms about CAM, and mixed, if they explored the positive and negative consequences of CAM in relation to conventional medicine.

[xxxii] There were slightly more negative stories—eight—compared with positive stories: five.
[xxxiii] "The new human genetics involves an alliance of global capital (notably the biotechnology industry), clinicans and scientisits from an array of disciplinary and national backgrounds, and politicians and social policy-makers concerned by the growing cost of health and welfare provision," (Kerr & Cunningham-Burley, 2000, p. 284). It also deals with genetic testing designed to help people decide whether to have children or undergo preventive medical procedures to avoid a genetic disease.

[xxxiv] This was the only pro-CAM piece on its movement into medical education.

[xxxv] See Dubrwiny (2013) for further discussion.
[xxxvi] She makes this statement because of the vast underrepresentation of women in the sciences. This is not part of my sample, but I included it because it illustrates how women in the sciences are aware of a patriarchal bias.
[xxxvii] A recent article published in the UK's *Telegraph* that studied how much time mothers and fathers spent caring for their children in 21 industrialized countries, including the U.S., found that women not only spent more time with their children than fathers but more time on care-taking activities including physical care and medical care.
In another article in *The Journal of Adolescent Health*, research found that both boys and girls talked to their mothers more about sex than their fathers or their friends. Because Gardasil is a vaccine for an STD, the chances that mothers may be more involved in the conversation about sex in relation to the vaccine are higher.

[xxxviii] See editorials by Sugarman (1998), Jonas (1998) and Eskinazi (1998).

[xxxix] This is not included in my data set because it was not about CAM, but about public engagement in science.

[xl] I use appearance and beauty interchangeably because there is a slippage with how conventional beauty standards, such as clear skin, shiny hair, and manicured nails are seen as indicators of health, while at the same time fitting into conventional standards of beauty.
[xli] This normalization is somewhat challenged by how women discuss their feelings about unrealistic beauty standards discussed in these media. I elaborate on this further in the next section.
[xlii] In one of my examples, a magazine editor expressed feelings of anxiety about being "vain", thus suggesting media producers also feel ambivalent about the place of beauty in women's lives.
[xliii] This is article is not included in my data set, but since I wasn't analyzing articles to look for discourses on vanity, I used a more recent example that I found.
[xliv] The study compares the amount of house management activities and energy expended performing these activities by women between 1965 and 2010.
[xlv] I don't go into detail on the idea that anyone is subject to health threats but this is frequently covered in mass media, where a person has no risk factor for a disease, and then suddenly falls ill.
[xlvi] See Petersen (1997) and Harding (1997) for an in-depth discussion on the constant presence of risk.
[xlvii] See the U.S. Department of Agriculture's Food and Nutrition Service website at: http://www.fns.usda.gov/eatsmartplayhardhealthylifestyle/default.html.
[xlviii] See the American Heart Association website: http://www.heart.org/HEARTORG/GettingHealthy/PhysicalActivity/Physical-Activity_UCM_001080_SubHomePage.jsp.
[xlix] The articles on fad dieting are not included in my data set because they are not feature articles.
[l] However, as I have asserted throughout, I do not argue that individualization is beneficial, as Beck at times does.
[li] I provided a similar story pertaining to phthalates in the introduction.
[lii] Indeed, as I will elaborate later in the chapter, branding is essential to the media I analyze—Oz's brand in particular is important to CAM proponents.
[liii] One is about the placebo effect, the other discusses it in the context of medical research on CAM.
[liv] See Applbaum 2006, Calfee 2002, and Macias, Pashupati, and Stavchansky, L.L. 2007
[lv] The *Dr. Oz* episode was about how to manage depression naturally, not about pharmaceutical companies.
[lvi] This was not part of my sample of programs.
[lvii] See Dubriwny (2013) for a discussion of how middle-class women are empowered in their health choices in ways in which lower-class women are not.

[lviii] One such example is a show in which Oz asks female audience members to go on a "prehistoric diet." The women volunteer to be locked in a public zoo for two days with nothing to eat but what the animals would get.

[lix] See Dubriwny 2013 for a discussion of how women are constructed as responsible for their family's health in contemporary risk constructions.

[lx] Rose (1992) provides an interesting discussion of the shifting relationship between experts and the lay population.